Evidence of Coverage

January 1st through
December 31

This Evidence of Coverage gives the details about your Medicare prescription drug coverage. It is an important legal document. Please keep it in a safe place.

Highmark Senior Resources
BlueRx Customer Service

For help or information, please call Customer Service Monday through Friday, 8:00 a.m. to 4:30 p.m. Calls to these numbers are free:

1-800-290-3914
TTY/TDD 1-800-988-0668
www.highmarkblueshield.com

HIGHMARK® BlueRx℠

A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

Highmark Blue Shield and Highmark Senior Resources are Independent Licensees of the Blue Cross and Blue Shield Association

S5593_05_080a (02/2006)
Contract Number S5593

Introduction: Welcome to BlueRx Basic

Section 1: Plan Basics

Section 2: Extra Help with Drug Plan Costs for People with Limited Income and Resources

Section 3: Monthly Premium

continued

Section 4: Prescription Drug Coverage

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Section 6: Appeals And Grievances: What To Do If You Have Complaints

continued

Section 7: Leaving this Plan and Your Choices for Continuing Prescription Drug Coverage after You Leave

Section 8: Your Rights and Responsibilities as a Member of this Plan

Section 9: Legal Notices

Section 10: Definitions of Some Words Used in This Evidence of Coverage

Welcome to BlueRx!

We are pleased that you've chosen our Plan

BlueRx Basic is a Medicare Prescription Drug Plan

Now that you are enrolled in BlueRx Basic, a Medicare Prescription Drug Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield.

Throughout the remainder of this Evidence of Coverage, we refer to BlueRx Basic as the "Plan."

This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our Plan

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. It also explains our responsibilities to you. The information in this Evidence of Coverage is in effect for the time period from January 1, 2006, through December 31, 2006.

This Evidence of Coverage gives you the details, including:

- What is covered in our Plan and what is not covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, including your choices for continuing Medicare prescription drug coverage.
- If you need this Evidence of Coverage in a different format (such as CDs or audiotapes), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time — your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

continued

How to contact our Plan's Customer Service

If you have any questions or concerns, please call or write to Customer Service. We will be happy to help you. Our business hours are Monday through Friday between 8:00 a.m. and 4:30 p.m.

CALL ***1-800-290-3914***. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

TTY/TDD ***1-800-988-0668***. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

WRITE ***BlueRx Member Service:***
– P.O. Box 890388
Camp Hill, PA 17089

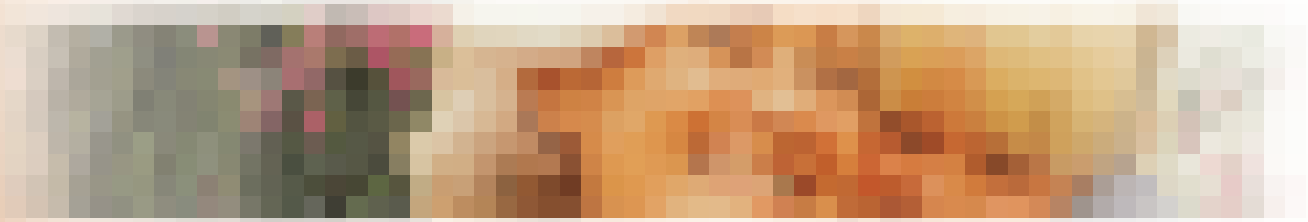
VISIT ***Our Customer Service Centers:***
– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106



How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Pennsylvania and West Virginia State Health Insurance Programs (SHIP)— *organizations in your state that provide free Medicare help and information*

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your state below. You can also find the Web site for your local SHIP at www.medicare.gov.

– **If you live in Pennsylvania**, you can contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m.

– **If you live in West Virginia**, contact the West Virginia Bureau of Senior Services at 1-304-558-3317,
1900 Kanawha Boulevard,
East Holly Grove, Building #10
Charleston, WV 25305-0160

continued

Pennsylvania and West Virginia QIO/Quality Improvement Organizations—*a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare*

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can find contact information for the QIO in your state below.

– **If you live in Pennsylvania**, contact:
Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-800-322-1914

– **If you live in West Virginia**, contact:
West Virginia Medical Institute
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686

Other organizations

Medicaid agency — a state government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact the following state Medicaid program:

– **If you live in Pennsylvania**, contact:
Pennsylvania Dept. of Public Welfare
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462

– **If you live in West Virginia**, contact:
West Virginia Dept. of Health and Human Services
350 Capitol Street, Room 251
Charleston, WV 25301-3709
1-304-558-1700

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits, you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums or the open enrollment season.

What is BlueRx Basic?

BlueRx Basic is offered by Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield, and is a Medicare Prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage

Medicare prescription drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other coverage rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and pay applicable copayments and coinsurances. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, copayments and coinsurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Service to learn more.

Help us keep your membership record up-to-date

We have a file of information about you as a Plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or from your current or former employer, or your spouse's current or former employer. In addition, you should tell Customer Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

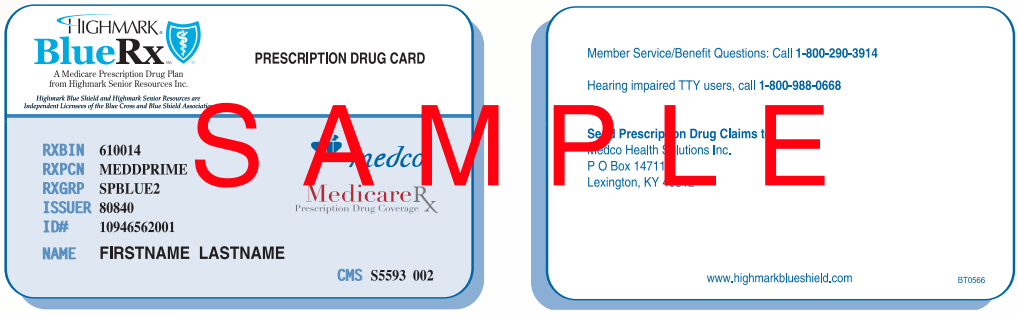
continued

What is the geographic service area for our Plan?

The states in our service area are listed below.
– Pennsylvania and West Virginia

Use your Plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of our Plan, you have a Plan membership card. *Here is a sample card to show what it looks like:*



During the time you are a plan member and using plan services, you *must* use your Plan membership card at network pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost or stolen, call Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered**.

– ***What is a "network pharmacy"?***

A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

– ***What are "covered drugs"?***

"Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

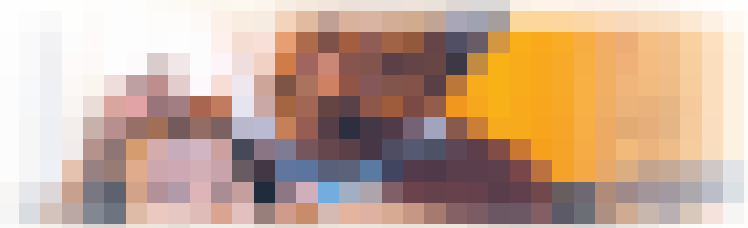
To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies

As a member of our Plan, we will send you a BlueRx Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.



How do I fill a prescription through the Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a one-day supply, and no more than a 90-day supply of the drug.

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Generally, it takes us eight days to process your order and ship it to you. However, sometimes your mail order may be delayed. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering through our mail order service. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail order prescription is being processed.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

- When you are traveling outside your Plan's service area and you run out of or lose your covered Part D drugs, or you become ill and need a covered Part D drug, and you cannot access a network pharmacy.
- You are not able to obtain a covered Part D drug in a timely manner within your service area because, for example, there is no network pharmacy within a reasonable driving distance that provides service 24 hours a day, seven days a week.
- Filling a prescription for a particular covered Part D drug (for example, an orphan drug or other specialty pharmaceutical) that is not regularly stocked at an accessible network retail or mail order pharmacy.
- The provided covered Part D drug is dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

BlueRx will reimburse you for our share of the cost of any covered Part D prescription drug you purchase from an out-of-network pharmacy; however, when you use an out-of-network pharmacy, you are responsible for paying the difference between the out-of-network price and the network pharmacy price *plus* your applicable network copayment or coinsurance.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Call BlueRx Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., and request a paper claim form. Mail your completed claim form along with your prescription drug receipts to the address printed on the form.

Specialty pharmacies

Home infusion pharmacies

The Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Service.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary and are covered by our Plan, but are not already covered by Medicare Part B. In addition, we cover some drugs that may be administered in your doctor's office. (Please see Section 4, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B," for more information.)

What extra help is available?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium and prescription copayments and coinsurances.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: *Amounts shown above are for 2006. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Customer Service to find out what the income limits are.*

Some people automatically qualify for extra help and do not have to apply for it.

If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the cover and in the introduction section. Or, visit our Web site.

Please Note: *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your Evidence of Coverage Rider.*

Paying the plan premium for your coverage as a member of our Plan

How much is your monthly plan premium and how do you pay it?

In BlueRx Basic, you must pay a $26.55 premium each month.

If you get your benefits from your current or former employer or from your spouse's current or former employer, call the employer's benefits administrator for information about your plan premium.

There are two ways to pay your monthly plan premium.

– ***Option One:***

Pay your plan premium directly to our Plan.

Monthly invoices for your BlueRx premiums will be mailed on or about the 12th day of each month. Your payment is due on the 1st day of the following month. For example, your bill for February coverage will be mailed on or about January 12 and is due on February 1. You may pay your monthly premium by check or money order (no cash), made payable to "Highmark Senior Resources." Mail your payment to: Highmark Blue Shield, P.O. Box 382057, Pittsburgh, PA 15250-8057. If you prefer, you can drop off your payment in person at any of the Customer Service centers listed in the Introduction section.

If you prefer, you can also have your premium automatically withdrawn from your bank account. This automatic premium payment program, called "Pay-It-Easy," is easy to set up and convenient to use. Simply call Customer Service and request an application. Automatic deductions are made monthly on the 1st day of each month.

– ***Option Two:***

You can have your monthly plan premium directly deducted from your monthly Social Security check. You can choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact Customer Service for more information on how to pay your premium this way.

Note: *If you choose to have your premium deducted from your Social Security check, we will only collect the premium amounts listed below, due to a minor computer processing issue. The small difference indicated in the table below requires no action on your part, absent further notice.*

States in Service Area	Rounded Down Premium	Total Yearly Difference
Pennsylvania and West Virginia	$26.50	$0.60

If you have any questions about your plan premiums or the different ways to pay them, please call our Customer Service numbers listed on the cover and in the Introduction section.

continued

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 60-day grace period begins. Failure to pay your past-due plan premiums within the 60-day grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

Please see Section 7 or call Customer Service to find out more about enrollment periods.

Can your plan premiums change during the year?

Generally, your plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, 2007.

In limited circumstances, your plan premium may change during the calendar year. If you aren't currently receiving extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. The Social Security Administration or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help.

Do you have to continue to pay your Part A or Part B premiums?

To be a member of our Plan, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this Plan.

Some members who belong to a Medicare Savings Program (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. Please see Section 2 or call Customer Service for more information.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

This section describes your prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

continued

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions" later in this section for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 ("Plan Basics") for more information about filling prescriptions at out-of-network pharmacies.

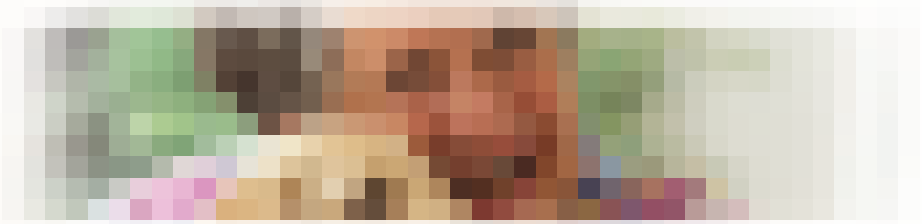
How do you find out what drugs are on the formulary?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drug is in. The table below shows the copayment amount you pay for each tier when you are in your initial coverage level. (See "How Much Do You Pay for Drugs Covered by this Plan?" on page page 32 of this document for more information about the initial coverage level.)

You can ask us to make an exception to your drug's tier placement. See Section 6 to learn more about how to request an exception.



Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations or quantity limits on a drug, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60 days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Customer Service to be sure it is not covered. *If Customer Service confirms that we do not cover your drug, you have three options:*

– You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service.

– You can ask us to make an exception to cover your drug. See Section 6 to learn more about how to request an exception.

– You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting a formulary exception. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 6 for more information on how to request an appeal.

If you recently joined this Plan and learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. *You can get a one-time fill of the non-covered drug if one of the following applies:*

– You didn't know that your drug wasn't covered by this Plan, or

– You knew it wasn't covered but you didn't know that you could request an exception to the Plan's formulary.

After your one-time fill, you can ask Customer Service if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See Section 6 to learn more about how to request an exception.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment.

The Highmark Medicare-approved Select Formulary includes a comprehensive list of medications designed to meet the needs of our members. Still, we want to make every effort to ensure that new and existing members experience a smooth transition into their prescription drug benefits in 2006 and beyond.

If you are currently taking a medication that is not included in the Highmark Medicare-approved Select Formulary, you or your doctor may request an exception for coverage of the medication. You may ask us for this exception before enrolling in the Plan to determine if your medication will be covered. You received a short version of the formulary list in your BlueRx enrollment materials. The entire formulary is available by calling Customer Service or visiting our Web site www.highmarkblueshield.com.

continued

After you are enrolled, if you fill a prescription for a medication that is not included in the formulary, you will be provided with a one-time fill for this medication at the pharmacy for your usual copayment or coinsurance. We will notify you and your doctor, if your doctor's information is available, that this one-time fill occurred. This will allow you time to work with your doctor to find an appropriate alternative medication that is on the formulary or request an exception for coverage of your medication.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. *These drugs or categories of drugs are called "exclusions" and include:*

Nonprescription drugs, unless they are part of an approved step therapy	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

Drug management programs

Utilization management

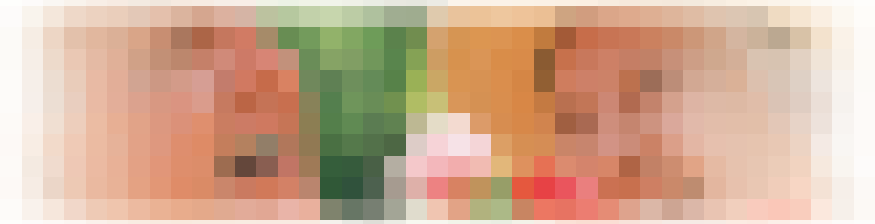
For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. *Examples of utilization management tools are described below:*

– ***Prior Authorization:*** We require you to get prior authorization for certain drugs. This means that you or your prescribing physician will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

– ***Quantity Limits:*** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to eight patches per prescription for Estraderm.

– ***Generic Substitution:*** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug. If you or your doctor request a brand name drug when a generic version is available, you will be responsible for paying the brand name copayment plus the difference in cost between the generic and brand name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See Section 6 to learn more about how to request an exception.



Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. *During these reviews, we look for medication problems such as:*

– Possible medication errors

– Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition

– Drugs that are inappropriate because of your age or gender

– Possible harmful interactions between drugs you are taking

– Drug allergies

– Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

continued

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

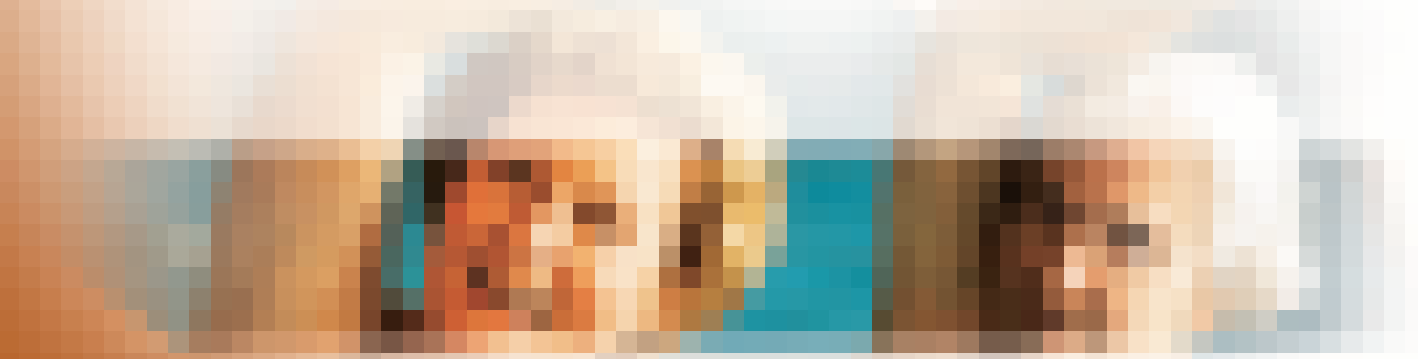
We offer a medication therapy management program for members who meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug is covered by Medicare Part A or Part B, it cannot be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases, but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.



How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2, "Extra Help with Drug Plan Costs for People with Limited Income and Resources," and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.

Initial coverage level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the **copayment**. Your copayment will vary depending on the drug and where the prescription is filled.

Drug Tier	Retail Copayment (34-day supply)	Retail Copayment (90-day supply)	Mail Order Copayment (90-day supply)	Out-of-Network Copayment (34-day supply)	Out-of-Network Copayment (90-day supply)
Formulary Generic	$10 Copayment	$30 Copayment	$25 Copayment	$10 Copayment plus difference between the network cost and the out-of-network charge	$30 Copayment plus difference between the network cost and the out-of-network charge
Formulary Brand Name	$30 Copayment	$90 Copayment	$75 Copayment	$30 Copayment plus difference between the network cost and the out-of-network charge	$90 Copayment plus difference between the network cost and the out-of-network charge

Once your total drug costs reach $2,250, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay or your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

continued

Coverage after you reach your initial coverage limit and before you qualify for catastrophic coverage

After your total drug costs reach $2,250, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $3,600, and you qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,600 out-of-pocket for the year. When the total amount you have paid toward copayments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of a $2 copayment for generics or formulary brand name drugs that are multi-source drugs and a $5 copayment for all other drugs, or 5% coinsurance. We will pay the rest.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by a Medicare Prescription Drug Plan, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

- Your coinsurance or copayments made on drugs normally covered in a Medicare Prescription Drug Plan that are:
  - Covered by the Plan up to the initial coverage level,
  - Not on our Plan's formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions or appeals process; and
  - Filled at an out-of-network pharmacy in accordance with our Plan's out-of-network access rules.
- Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.

*Purchases that will **not** count toward your out-of-pocket costs:*

– Prescription drugs purchased outside the United States and its territories;

– Prescription drugs not covered by the Plan.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for prescription drugs normally covered by a Medicare Prescription Drug Plan count toward your out-of-pocket costs and will help you qualify for catastrophic coverage.

In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

– Family members or other individuals;

– Qualified State Pharmacy Assistance Programs (SPAPs);

– Medicare programs that provide extra help with prescription drug coverage; and

– Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

*Payments made by the following do **not** count toward your out-of-pocket costs:*

– Group Health Plans;

– Insurance Plans and government funded health programs (e.g., TRICARE, the Indian Health Service); and

– Third-party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation).

If you have coverage from a third-party that pays a part of or all of your out-of-pocket costs, you must disclose this information to us. An example of third-party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

continued

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
  - ***Amount Paid for Prescriptions—***
    The amounts paid that count towards your initial coverage limit.
  - ***Out-of-Pocket Payments after You Reach the Initial Coverage Limit—***
    The amount you and/or others make after you reach the initial coverage limit and before you qualify for catastrophic coverage.
  - ***Total Out-of-Pocket Costs that Count Towards Catastrophic Coverage—***
    The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your copayments and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

When will you get your Explanation of Benefits?

You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us.

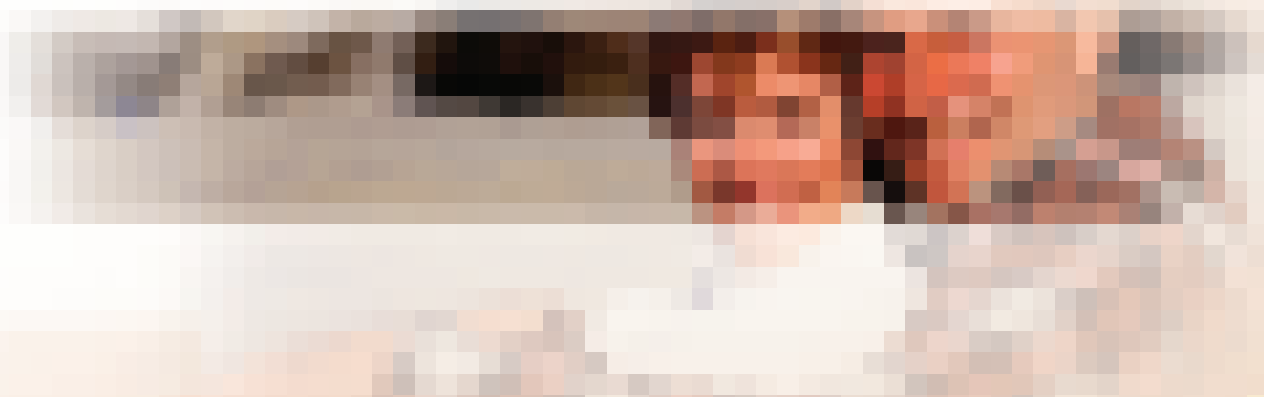
What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.



We will send you a CMS Secondary Payer Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your copayments. Please contact your SPAP to determine what benefits are available to you.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy **that includes coverage for prescription drugs,** you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

If you are a member of an employer or retiree group

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group.

In the fall of 2005, your employer or retiree group sent a letter that indicated whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not get this letter, please contact your benefits administrator.

If you are enrolled in a Medicare-approved drug discount card program

If you have a Medicare-approved drug discount card, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are enrolled in a non-Medicare-approved drug discount card program

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and covered by us can count towards your out-of-pocket expenses. Contact Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., for a claim form. Follow the instructions printed on the claim form.

continued

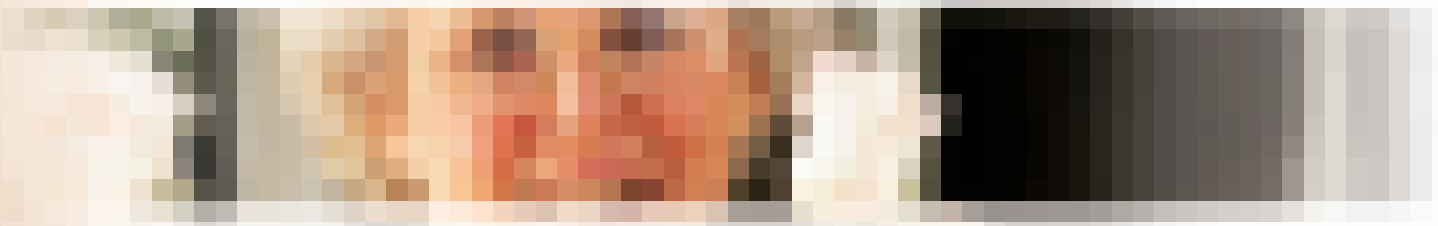
What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Customer Service numbers listed on the cover.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations and appeals.



What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower copayment. If you request an exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part of Section 6 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

– You feel that you are being encouraged to leave (disenroll from) our Plan.

– Problems with the customer service you receive.

– Problems with how long you have to spend waiting on the phone or in the pharmacy.

– Disrespectful or rude behavior by pharmacists or other staff.

– Cleanliness or condition of pharmacy.

– If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.

– You believe our notices and other written materials are difficult to understand.

– Failure to give you a decision within the required timeframe.

– Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.

– Failure by the plan sponsor to provide required notices.

– Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Customer Service at the numbers listed on the cover. **We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the BlueRx Part D Grievance Procedure.**

continued

The BlueRx Fast-Track Grievance Procedure is as follows:

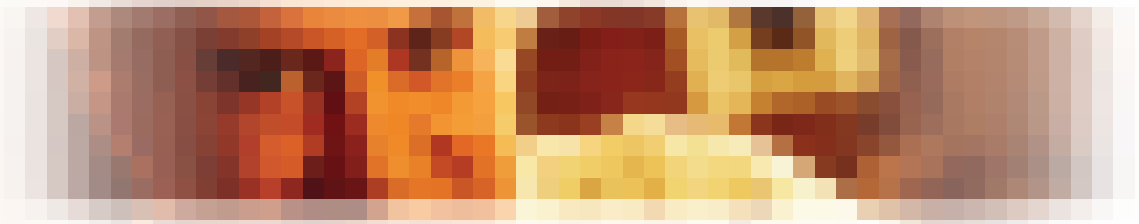
The fast-track grievance procedures are used in the following instance:

– If you disagree with the decision made by Highmark BlueRx not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the BlueRx Customer Service department. You may call 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m. Outside these hours, please call 1-800-485-9610 (TTY users, call 1-888-422-1226).

– You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest.

– Highmark will review your complaint and take the appropriate steps to investigate your complaint. Highmark will respond in writing within 24 hours from the date the BlueRx Grievance department receives your complaint.



The BlueRx Standard Grievance Procedure is as follows:

– Your initial inquiry should be directed to the BlueRx Customer Service department. If you are dissatisfied with the response to your inquiry, you can ask for a First Level Complaint Review. Your complaint for review should be made in writing. Your written complaint may include written information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests in writing.

Send your written complaint to:

Highmark BlueRx Appeals and Grievance Department
P.O. Box 535047
Pittsburgh, PA 15253-5074
Fax # 1-412-544-1513

– Highmark will review your written complaint. For complaints regarding such issues as waiting times, pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, Highmark will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the pharmacy provider, a review of the medical records or ongoing provider monitoring. Highmark will respond in writing within 30 days or as expeditiously as the case requires.

– Complaints that do not involve pharmacy providers or general dissatisfaction with the Part D plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 days or as expeditiously as the case requires. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 days from the date the decision is received and may include any written supporting material from you or any party of interest.

– The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee member will not be a Highmark employee, but they must be a member of a Highmark health care plan. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Highmark will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the Committee. The hearing will be held within 30 days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.

– The decision of the Second Level Complaint Committee will be binding.

– For further information regarding the purposes and operations of the grievance procedure, contact Highmark BlueRx Customer Service.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare Prescription Drug Plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

continued

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part of Section 6 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a coverage determination.

The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by us.
- If you have received a Part D prescription drug you believe may be covered by us while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled, "Detailed information about how to request a coverage determination and an appeal."

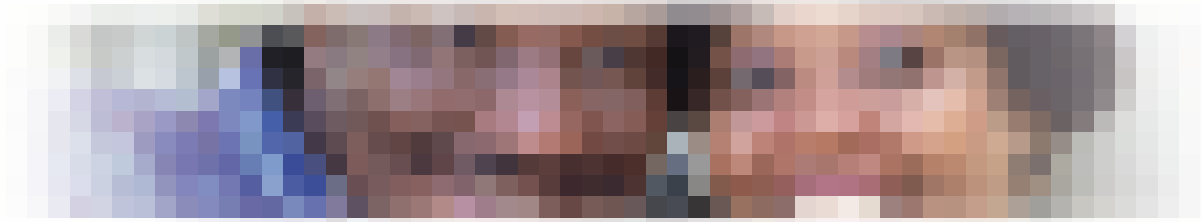
How to request an appeal

This part of Section 6 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request (described in Section 4 of this document), you can appeal. A coverage determination, which includes those described on page 45, may be appealed if you disagree with our decision.

Note: *If we approve your exception request for a non-formulary drug, you cannot request an exception to the copayment we require you to pay for the drug.*



How does the appeals process work?

There are five levels to the appeals process.

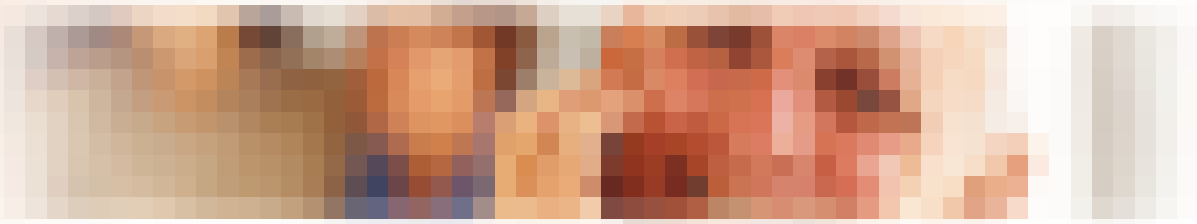
Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

continued

Each appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal."



Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage determinations—*Our Plan makes a coverage determination about your Part D prescription drug, or about paying for a Part D drug you have already received*

What is a coverage determination?

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact our Plan and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" our decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

– You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service to get help in making this request.

– You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can refer to our Customer Service to ask for this type of decision.

– You ask for an exception to our plan's utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call Customer Service to ask for this type of decision.

– You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the Plan. See Section 1 for a description of these circumstances. You can refer to our Customer Service to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a doctor's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by our Plan).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at BlueRx Member Service Department, P.O. Box 890388, Camp Hill, PA 17089. You can call Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

continued

Asking for a "Standard" or "Fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Customer Service numbers listed on the cover and in the Introduction section for assistance. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546. Be sure to ask for a "fast," "expedited" or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

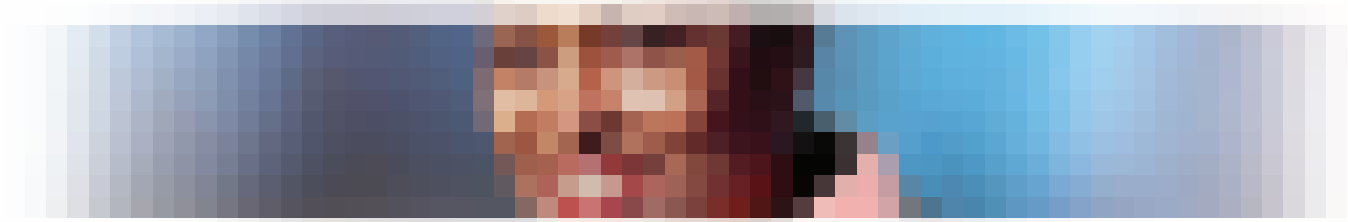
If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**



We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast coverage determination about a Part D drug that you have not received.*

   If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review — sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

continued

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72-hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

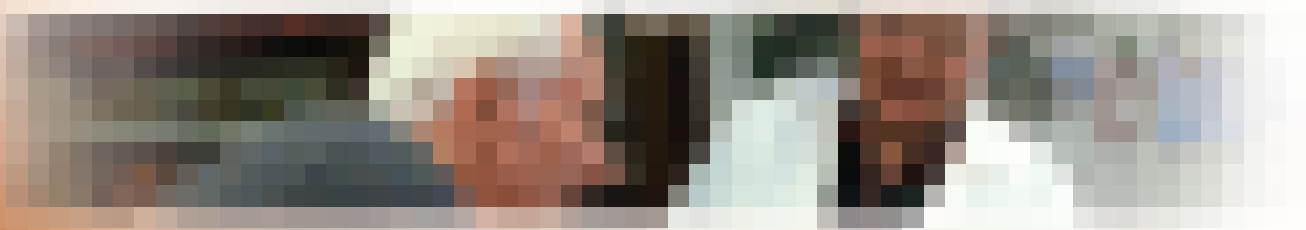
   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. *For a fast decision about a Part D drug that you have not received.*

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).



Appeal Level 1—*If we deny all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."*

Please call Customer Service if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision." While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different — please refer to "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

In writing: *BlueRx Appeals and Grievance Department*
P.O. Box 535047
Pittsburgh, PA 15253-5047.

By fax, at ***1-412-544-1513***.

By telephone *— if it is a fast appeal — at 1-800-485-9610; TTY users—1-888-422-1226*.

continued

In person, at any of the following walk-in centers:

– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-800-290-3914 (TTY users, call 1-800-988-0668) or write us at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your appeal?

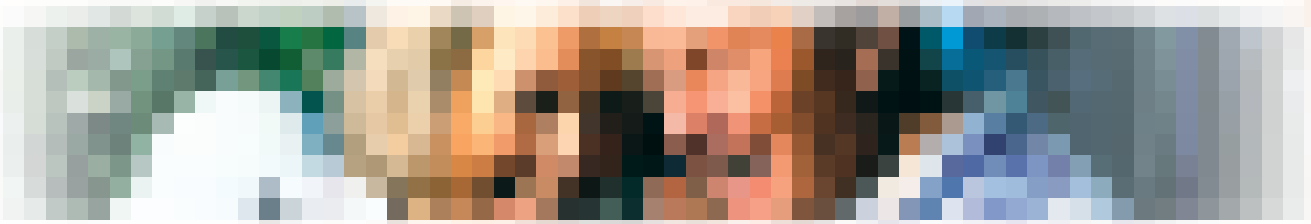
You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to BlueRx Expedited Review Department,

P.O. Box 535073, Pittsburgh, PA 15253-5073 or fax it to 1-800-894-7947. For requests that are made outside of regular weekday business hours, call BlueRx Expedited Review at 1-800-485-9610 (TTY users, call 1-888-422-1226). Be sure to ask for a "fast," "expedited" or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. *While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Send your standard appeal requests to BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047. Send your expedited appeal requests to BlueRx Expedited Review Department, P.O. Box 535073, Pittsburgh, PA 15253-5073.*



How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

   After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

   After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must send payment to you no later than 30 calendar days after we get your request to reconsider our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

continued

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

Appeal Level 2—*If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization*

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you — only you or your appointed representative may file the request.

If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.*
2. *For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.*

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must pay within 30 calendar days from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

continued

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110.00 or more.

Appeal Level 3—*If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge*

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to Department of Health and Human Services, Office of Medicare Hearings & Appeals, 200 Public Square, Suite 1300, Cleveland, OH 44114-2316.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110.00. If the dollar value is less than $110.00, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.
2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

continued

Appeal Level 4—*Your case may be reviewed by the Medicare Appeals Council*

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.
2. *For a standard decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. *For a fast decision about a Part D drug you have not received.*
   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

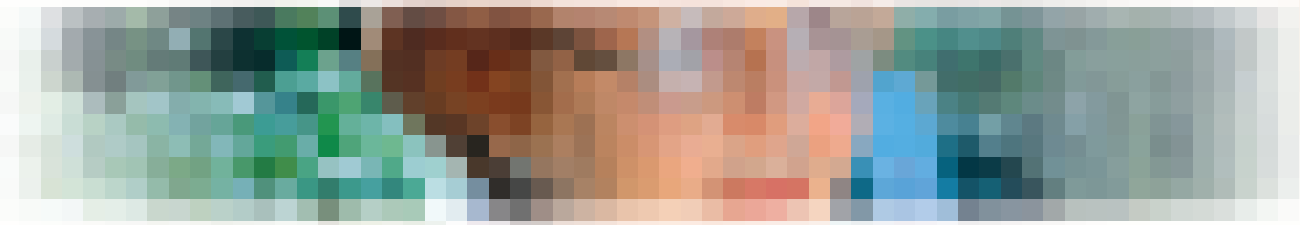
If the Council decides against you

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5— *Your case may go to a Federal Court*

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.



How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once we get notice of a judicial decision in your favor, *what happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you within 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge decides against you

The Judge's decision is final and you may not take the appeal any further.

What is "disenrollment"?

"Disenrollment" from our Plan means ending your membership with us. **Disenrollment can be** voluntary **(your own choice)** or, in limited circumstances, involuntary **(not your own choice):**

– You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (see "When Can You Disenroll/Switch Prescription Drug Plans?" below).

– There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you move out of our geographic service area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your Rx

If you leave our Plan, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can disenroll from your plan at other times. After you request to disenroll, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy or through our mail order pharmacy service, are listed on our formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Customer Service numbers listed on the cover and in the Introduction section.

continued

What are your options for getting Rx drug coverage if you leave our Plan?

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage *if* this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage. If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must get your Medicare prescription drug coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

You may also be able to get back the prescription drug coverage you had before you enrolled in our Plan. Please contact your previous Prescription Drug Plan for more information.

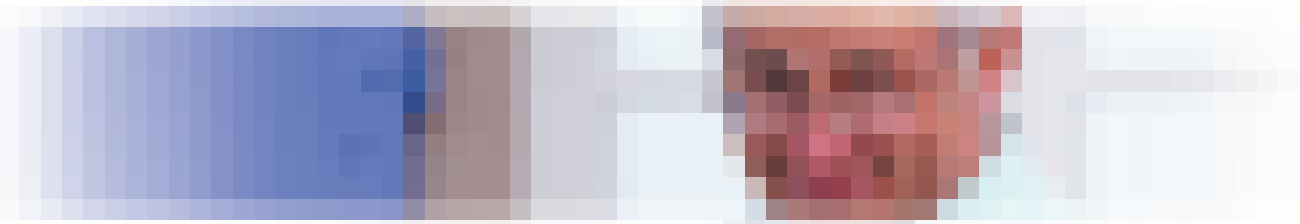
Note: *If you disenroll from our Plan and do not enroll in another Medicare Prescription Drug Plan, or have other prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a penalty if you enroll in a Medicare Prescription Drug Plan at a later date. Refer to Section 3 for more information on the penalty.*

When can you disenroll/switch Medicare Prescription Drug Plans?

In general, you may only disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances.

You can switch your Prescription Drug Plan during the following periods:

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006), you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you did not get this letter, contact the issuer of your Medigap policy.



Annual Coordinated Election Period

During the Annual Coordinated Election Period, anyone with prescription drug coverage may disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare prescription drug coverage.

For coverage beginning in 2006, the annual coordination election period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the annual coordinated election period goes from November 15 through December 31 of each year.

Please remember, if during this election period you disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare prescription drug coverage in the future.

If you join another Prescription Drug Plan during the annual coordinated election period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

Exception for January 1, 2006 through May 15, 2006: If you disenroll from our Plan to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

continued

Special Enrollment Period

Generally, you may not disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year *unless* you qualify for a Special Enrollment Period.

In order to qualify for a Special Enrollment Period, one of the following must apply to you:

– Our Plan no longer offers prescription drug coverage in the area where you live.

– You move outside our Plan's service area.

– You have an involuntary loss of creditable prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.

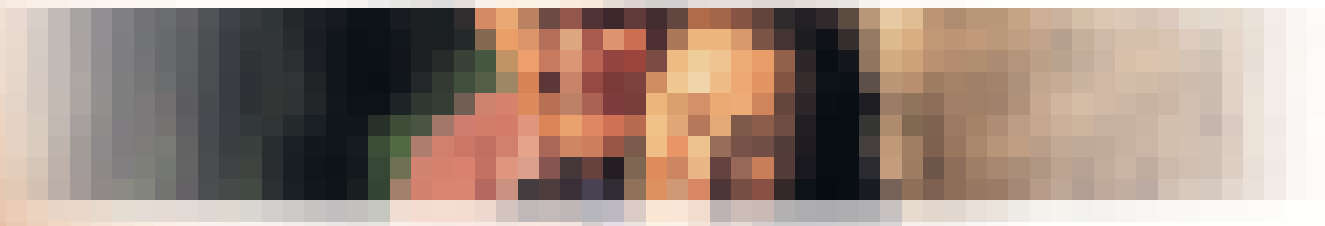
– You were not adequately informed about your loss of creditable prescription drug coverage, or you were not adequately informed that you never had creditable prescription drug coverage.

– Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.

– You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.

– Our Plan's contract with the Centers for Medicare & Medicaid Services is terminated.

– You were a member of a Medicare Advantage Plan with prescription drug coverage and decided to join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.



– You are able to demonstrate that our Plan has substantially violated a material provision in its contract. *This includes, but is not limited to:*

  – If our Plan failed to provide you with prescription drug coverage in a timely manner.

  – If our Plan failed to provide your prescription drug coverage with applicable quality standards.

  – You are able to demonstrate that our Plan misrepresented itself in its marketing.

– You are enrolling in or disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse's current or former employer.

– In certain cases in which the Plan is sanctioned by the Centers for Medicare & Medicaid Services.

– You enroll in or disenroll from your state's Program of All-Inclusive Care for the Elderly.

– You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.

– You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.

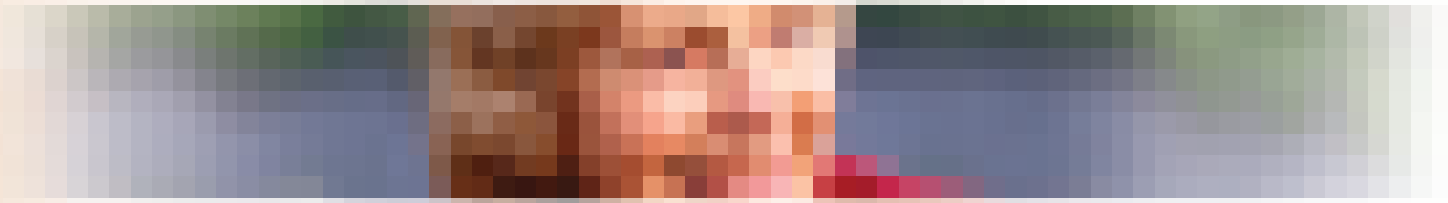
In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Service and we will assist you.

How do you disenroll?

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a disenrollment request. Your request should include your name, Medicare number, Social Security number, date of birth, and requested disenrollment date. (Please note that we may not be able to disenroll you on the date you request.) Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can mail a letter to us at BlueRx Enrollment Department, P.O. Box 535049, Pittsburgh, PA 15253-5049 or fax it to us at 1-412-544-2111. You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

continued

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your "disenrollment date"). Remember, you are still a member of our Plan until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.



When can the Plan disenroll you?

Our Plan can disenroll you for the following reasons:

– You are no longer eligible for Medicare prescription drug coverage.

– If our Plan is no longer contracting with Medicare or leaves your service area.

– When you move out of our Plan's service area.

– You materially misrepresent third-party reimbursement.

– You fail to pay your Plan premium.

– You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.

If you are no longer eligible for Medicare prescription drug coverage

If you lose your eligibility for Medicare prescription drug coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan's service area.

When the Plan is no longer contracting with Medicare or leaves your service area

If we leave the Medicare program or no longer offer prescription drug coverage in the service area where you live, we will notify you in writing. If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's network pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan. (See "When Can You Disenroll/Switch Prescription Drug Plans?" on page 64 for specific information on special enrollment periods.)

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When you move out of our Plan's service area

If you plan to move, please call our Customer Service numbers listed on the cover and in the Introduction section to find out if the place you are moving to is in our Plan's service area. If you move permanently out of our service area, you will need to leave ("disenroll" from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

You materially misrepresent third-party reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third-party reimbursement, our Plan has the right to decline you future enrollment in our Prescription Drug Plan.

continued

You fail to pay the Plan premium

If you fail to pay your Plan premium, our Plan has the right to disenroll you. Our Plan will send you a written notice in an effort to collect the unpaid premiums. Failure to comply with payment will result in disenrollment from the Plan.

In addition, if you are disenrolled from Plan for failure to pay your premium, Plan has the right to decline your future enrollment in our Prescription Drug Plan until your debt has been paid.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as standard Medicare prescription drug coverage for 63 days or longer, then you will pay a penalty the next time you enroll in a Medicare Prescription Drug Plan.

You engage in disruptive behavior, provide fraudulent information when you enroll or abuse your enrollment card

You may be asked to leave our Plan in the following circumstances:

– If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are members of our Plan. We cannot make you leave (i.e., disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.

– If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.

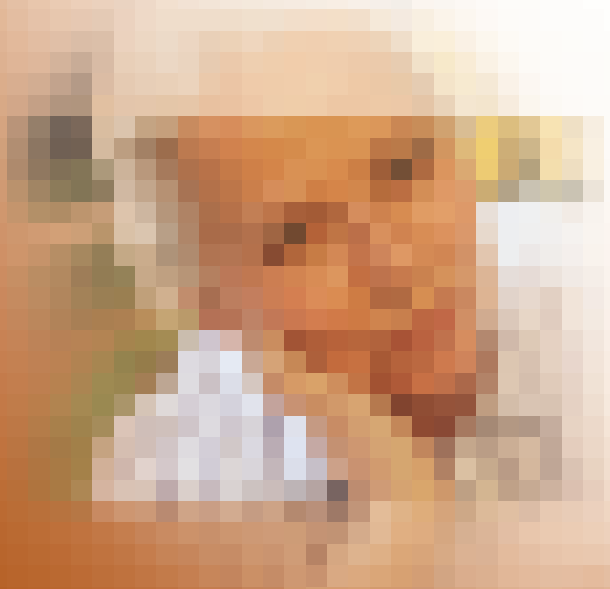
– If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We cannot ask you to leave our Plan because of your health

No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our Plan

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.



Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area:

Office for Civil Rights, Philadelphia Office
U.S. Dept. of Education
Wanamaker Building
100 Penn Square East, Suite 515
Philadelphia, PA 19107-3323
Telephone: 1-215-656-8541
Fax: 1-215-656-8605

If you need help with communication, such as help from a language interpreter, please call our Customer Service numbers listed on the cover.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

continued

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Customer Service numbers listed on the cover.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a network pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 6.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 6.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* us in the past. To get this information, call our Customer Service numbers listed on the cover.

Your right to get information about your drug coverage and costs

This Evidence of Coverage tells you what you have to pay for prescription drugs as a member of the Plan. If you need more information, please call our Customer Service numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about Highmark Senior Resources Inc. and BlueRx Plans. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone number listed on the cover.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Service numbers listed on the cover and in the Introduction section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction, page 10, tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

continued

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Service numbers listed on the cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

What are your responsibilities as a member of our Plan?

Along with the rights you have as a member of our Plan, you also have some responsibilities.

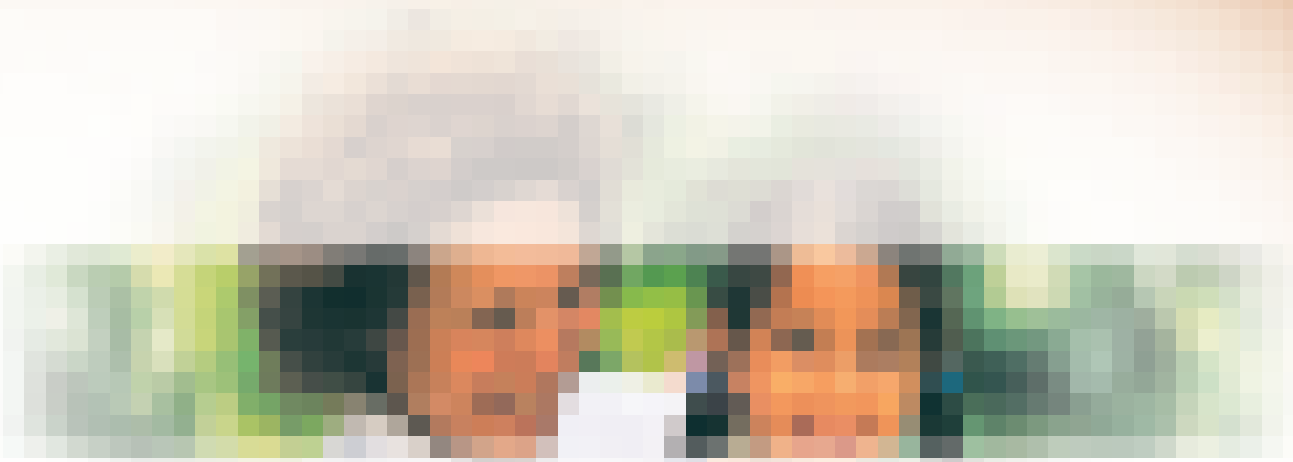
Your responsibilities include the following:

– Become familiar with your coverage and the rules you must follow to get care as a member. You can use this Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone numbers listed on the cover if you have any questions.

– Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

– Pay your plan premiums and any copayments you may owe for the covered drugs you get. You must also meet your other financial responsibilities that are described in Section 3.

– Let us know if you have any questions, concerns, problems or suggestions. If you do, please call our Customer Service numbers listed on the cover.



Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of your state may also apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like us, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

For the terms listed below, this section either gives a definition or directs you to a place in this Evidence of Coverage that explains the term

Appeal – A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug. Section 6 explains what appeals are, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are sometimes not available until after the patent on the brand-name drug has expired. Section 4 explains Plan coverage for brand name drugs.

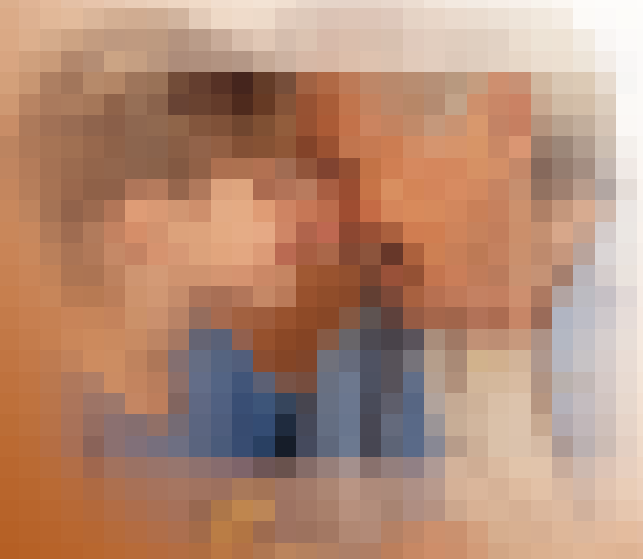
Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination – The decision the Plan makes about the prescription drug benefits you are entitled to get under the plan, and the amount that you are required to pay for a drug. Section 6 discusses these decisions.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan. Section 4 tells you what drugs are covered by BlueRx.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage. Section 5, "If you are a member of an employer or retiree group" mentions creditable coverage.

Customer Service – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact Customer Service.



Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses disenrollment.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception). See Section 6.

Formulary – A list of covered drugs provided by the plan. Section 4 talks about our formulary.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Section 4 explains Plan coverage for generic drugs.

Grievance - A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about grievances.

Late Enrollment Penalty – If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium. See Section 3.

Medically Necessary – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor. See Section 4.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). See Introduction.

continued

Medicare Advantage Plan with Prescription Drug Coverage – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. See Section 7.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. See Section 1.

"Medigap" (Medicare supplement insurance) Policy – Many people who have Original Medicare also buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage. See Section 5.

Member (member of our Plan) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS). See Section 5.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. See Section 1.

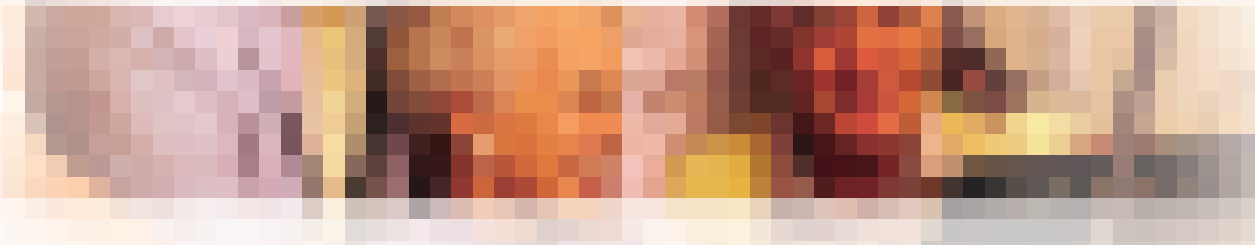
Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug unless it is covered under Part A or Part B. See Section 4.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some services are covered only if your doctor or other plan provider gets "prior authorization" from us. Covered services that need prior authorization are marked in the formulary. See Section 4.

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan. See Section 1.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. See Section 2.



HIGHMARK.
BlueRx℠

A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

23169 (2-06) 96M

Evidence of Coverage

January 1st through
December 31

This Evidence of Coverage gives the details about your Medicare prescription drug coverage. It is an important legal document. Please keep it in a safe place.

Highmark Senior Resources
BlueRx Customer Service

For help or information, please call Customer Service Monday through Friday, 8:00 a.m. to 4:30 p.m. Calls to these numbers are free:

1-800-290-3914
TTY/TDD 1-800-988-0668
www.highmarkblueshield.com

HIGHMARK® BlueRx℠

A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

Highmark Blue Shield and Highmark Senior Resources are Independent Licensees of the Blue Cross and Blue Shield Association

S5593_05_078a (02/2006)
Contract Number S5593

Introduction: Welcome to BlueRx Plus

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Welcome to BlueRx!

We are pleased that you've chosen our Plan

BlueRx Plus is a Medicare Prescription Drug Plan

Now that you are enrolled in BlueRx Plus, a Medicare Prescription Drug Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield.

Throughout the remainder of this Evidence of Coverage, we refer to BlueRx Plus as the "Plan."

This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our Plan

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. It also explains our responsibilities to you. The information in this Evidence of Coverage is in effect for the time period from January 1, 2006, through December 31, 2006.

This Evidence of Coverage gives you the details, including:

– What is covered in our Plan and what is not covered.

– How to get your prescriptions filled, including some rules you must follow.

– What you will have to pay for your prescriptions.

– What to do if you are unhappy about something related to getting your prescriptions filled.

– How to leave our Plan, including your choices for continuing Medicare prescription drug coverage.

– If you need this Evidence of Coverage in a different format (such as CDs or audiotapes), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time — your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

continued

How to contact our Plan's Customer Service

If you have any questions or concerns, please call or write to Customer Service. We will be happy to help you. Our business hours are Monday through Friday between 8:00 a.m. and 4:30 p.m.

CALL ***1-800-290-3914***. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

TTY/TDD ***1-800-988-0668***. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

WRITE ***BlueRx Member Service:***
– P.O. Box 890388
Camp Hill, PA 17089

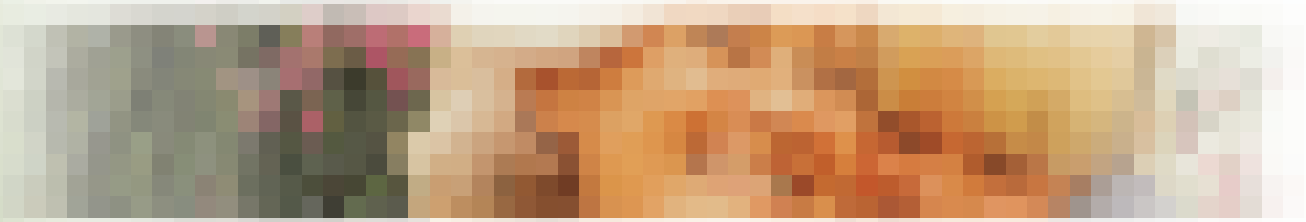
VISIT ***Our Customer Service Centers:***
– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106



How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Pennsylvania and West Virginia State Health Insurance Programs (SHIP)— *organizations in your state that provide free Medicare help and information*

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your state below. You can also find the Web site for your local SHIP at www.medicare.gov.

– **If you live in Pennsylvania**, you can contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m.

– **If you live in West Virginia**, contact the West Virginia Bureau of Senior Services at 1-304-558-3317,
1900 Kanawha Boulevard,
East Holly Grove, Building #10
Charleston, WV 25305-0160

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Pennsylvania and West Virginia QIO/Quality Improvement Organizations—*a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare*

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can find contact information for the QIO in your state below.

– **If you live in Pennsylvania**, contact:
Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-800-322-1914

– **If you live in West Virginia**, contact:
West Virginia Medical Institute
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686

Other organizations

Medicaid agency — a state government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact the following state Medicaid program:

– **If you live in Pennsylvania**, contact:
Pennsylvania Dept. of Public Welfare
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462

– **If you live in West Virginia**, contact:
West Virginia Dept. of Health and Human Services
350 Capitol Street, Room 251
Charleston, WV 25301-3709
1-304-558-1700

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits, you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums or the open enrollment season.

What is BlueRx Plus?

BlueRx Plus is offered by Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield, and is a Medicare Prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage

Medicare prescription drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other coverage rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and pay applicable copayments and coinsurances. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, copayments and coinsurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Service to learn more.

Help us keep your membership record up-to-date

We have a file of information about you as a Plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or from your current or former employer, or your spouse's current or former employer. In addition, you should tell Customer Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

continued

What is the geographic service area for our Plan?

The states in our service area are listed below.
– Pennsylvania and West Virginia

Use your Plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of our Plan, you have a Plan membership card. *Here is a sample card to show what it looks like:*

During the time you are a plan member and using plan services, you *must* use your Plan membership card at network pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost or stolen, call Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered**.

– ***What is a "network pharmacy"?***

A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

– ***What are "covered drugs"?***

"Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies

As a member of our Plan, we will send you a BlueRx Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do I fill a prescription through the Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a one-day supply, and no more than a 90-day supply of the drug.

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Generally, it takes us eight days to process your order and ship it to you. However, sometimes your mail order may be delayed. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering through our mail order service. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail order prescription is being processed.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

- When you are traveling outside your Plan's service area and you run out of or lose your covered Part D drugs, or you become ill and need a covered Part D drug, and you cannot access a network pharmacy.
- You are not able to obtain a covered Part D drug in a timely manner within your service area because, for example, there is no network pharmacy within a reasonable driving distance that provides service 24 hours a day, seven days a week.
- Filling a prescription for a particular covered Part D drug (for example, an orphan drug or other specialty pharmaceutical) that is not regularly stocked at an accessible network retail or mail order pharmacy.
- The provided covered Part D drug is dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

BlueRx will reimburse you for our share of the cost of any covered Part D prescription drug you purchase from an out-of-network pharmacy; however, when you use an out-of-network pharmacy, you are responsible for paying the difference between the out-of-network price and the network pharmacy price *plus* your applicable network copayment or coinsurance.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Call BlueRx Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., and request a paper claim form. Mail your completed claim form along with your prescription drug receipts to the address printed on the form.

Specialty pharmacies

Home infusion pharmacies

The Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Service.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary and are covered by our Plan, but are not already covered by Medicare Part B. In addition, we cover some drugs that may be administered in your doctor's office. (Please see Section 4, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B," for more information.)

What extra help is available?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium and prescription copayments and coinsurances.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: *Amounts shown above are for 2006. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Customer Service to find out what the income limits are.*

Some people automatically qualify for extra help and do not have to apply for it.

If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the cover and in the introduction section. Or, visit our Web site.

Please Note: *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your Evidence of Coverage Rider.*

Paying the plan premium for your coverage as a member of our Plan

How much is your monthly plan premium and how do you pay it?

In BlueRx Plus, you must pay a $33.67 premium each month.

If you get your benefits from your current or former employer or from your spouse's current or former employer, call the employer's benefits administrator for information about your plan premium.

There are two ways to pay your monthly plan premium.

– ***Option One:***

Pay your plan premium directly to our Plan.

Monthly invoices for your BlueRx premiums will be mailed on or about the 12th day of each month. Your payment is due on the 1st day of the following month. For example, your bill for February coverage will be mailed on or about January 12 and is due on February 1. You may pay your monthly premium by check or money order (no cash), made payable to "Highmark Senior Resources." Mail your payment to: Highmark Blue Shield, P.O. Box 382057, Pittsburgh, PA 15250-8057. If you prefer, you can drop off your payment in person at any of the Customer Service centers listed in the Introduction section.

If you prefer, you can also have your premium automatically withdrawn from your bank account. This automatic premium payment program, called "Pay-It-Easy," is easy to set up and convenient to use. Simply call Customer Service and request an application. Automatic deductions are made monthly on the 1st day of each month.

– ***Option Two:***

You can have your monthly plan premium directly deducted from your monthly Social Security check. You can choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact Customer Service for more information on how to pay your premium this way.

Note: *If you choose to have your premium deducted from your Social Security check, we will only collect the premium amounts listed below, due to a minor computer processing issue. The small difference indicated in the table below requires no action on your part, absent further notice.*

States in Service Area	Rounded Down Premium	Total Yearly Difference
Pennsylvania and West Virginia	$33.60	$0.84

If you have any questions about your plan premiums or the different ways to pay them, please call our Customer Service numbers listed on the cover and in the Introduction section.

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What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 60-day grace period begins. Failure to pay your past-due plan premiums within the 60-day grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

Please see Section 7 or call Customer Service to find out more about enrollment periods.

Can your plan premiums change during the year?

Generally, your plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, 2007.

In limited circumstances, your plan premium may change during the calendar year. If you aren't currently receiving extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. The Social Security Administration or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help.

Do you have to continue to pay your Part A or Part B premiums?

To be a member of our Plan, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this Plan.

Some members who belong to a Medicare Savings Program (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. Please see Section 2 or call Customer Service for more information.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

This section describes your prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

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Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions" later in this section for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 ("Plan Basics") for more information about filling prescriptions at out-of-network pharmacies.

How do you find out what drugs are on the formulary?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drug is in. The table below shows the copayment amount you pay for each tier when you are in your initial coverage level. (See "How Much Do You Pay for Drugs Covered by this Plan?" on page 32 of this document for more information about the initial coverage level.)

You can ask us to make an exception to your drug's tier placement. See Section 6 to learn more about how to request an exception.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations or quantity limits on a drug, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60 days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Customer Service to be sure it is not covered. *If Customer Service confirms that we do not cover your drug, you have three options:*

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service.
- You can ask us to make an exception to cover your drug. See Section 6 to learn more about how to request an exception.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting a formulary exception. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 6 for more information on how to request an appeal.

If you recently joined this Plan and learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. *You can get a one-time fill of the non-covered drug if one of the following applies:*

- You didn't know that your drug wasn't covered by this Plan, or
- You knew it wasn't covered but you didn't know that you could request an exception to the Plan's formulary.

After your one-time fill, you can ask Customer Service if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See Section 6 to learn more about how to request an exception.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment.

The Highmark Medicare-approved Choice Formulary includes a comprehensive list of medications designed to meet the needs of our members. Still, we want to make every effort to ensure that new and existing members experience a smooth transition into their prescription drug benefits in 2006 and beyond.

If you are currently taking a medication that is not included in the Highmark Medicare-approved Choice Formulary, you or your doctor may request a tier exception for coverage of that medication at the brand copayment instead of the non-formulary brand copayment. You may ask us for this exception before enrolling in the Plan to determine if your medication will be covered at the brand copayment. You received a short version of the formulary list in your BlueRx enrollment materials. The entire formulary is available by calling Customer Service or visiting our Web site www.highmarkblueshield.com.

continued

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. *These drugs or categories of drugs are called "exclusions" and include:*

Nonprescription drugs, unless they are part of an approved step therapy	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

Drug management programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. *Examples of utilization management tools are described below:*

- ***Prior Authorization:*** We require you to get prior authorization for certain drugs. This means that you or your prescribing physician will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- ***Quantity Limits:*** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to eight patches per prescription for Estraderm.
- ***Generic Substitution:*** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug. If you or your doctor request a brand name drug when a generic version is available, you will be responsible for paying the brand name copayment plus the difference in cost between the generic and brand name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See Section 6 to learn more about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. *During these reviews, we look for medication problems such as:*

– Possible medication errors

– Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition

– Drugs that are inappropriate because of your age or gender

– Possible harmful interactions between drugs you are taking

– Drug allergies

– Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

continued

We offer a medication therapy management program for members who meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

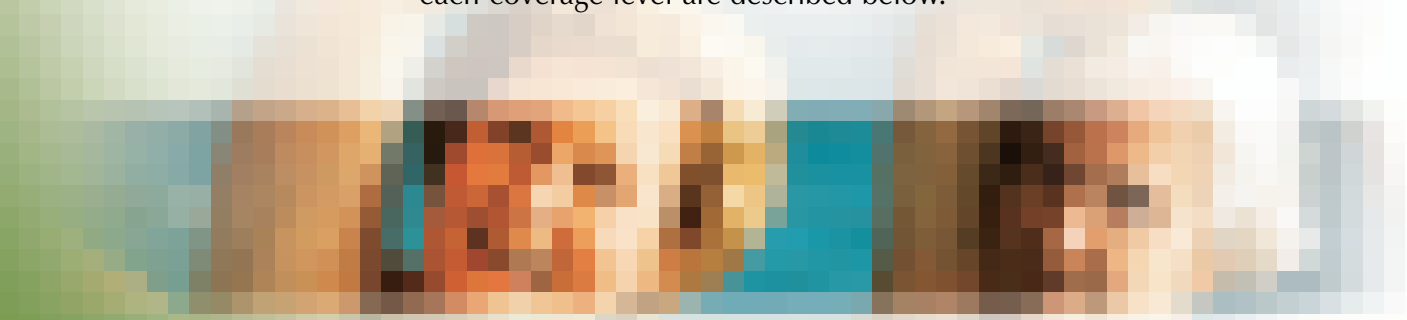
Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug is covered by Medicare Part A or Part B, it cannot be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases, but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2, "Extra Help with Drug Plan Costs for People with Limited Income and Resources," and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.



Initial coverage level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the **copayment**. Your copayment will vary depending on the drug and where the prescription is filled.

Drug Tier	Retail Copayment (34-day supply)	Retail Copayment (90-day supply)	Mail Order Copayment (90-day supply)	Out-of-Network Copayment (34-day supply)	Out-of-Network Copayment (90-day supply)
Formulary Generic	$10 Copayment	$30 Copayment	$25 Copayment	$10 Copayment plus difference between the network cost and the out-of-network charge	$30 Copayment plus difference between the network cost and the out-of-network charge
Formulary Brand Name	$25 Copayment	$75 Copayment	$62.50 Copayment	$25 Copayment plus difference between the network cost and the out-of-network charge	$75 Copayment plus difference between the network cost and the out-of-network charge
Non-Preferred Brand Name	$45 Copayment	$135 Copayment	$112.50 Copayment	$45 Copayment plus difference between the network cost and the out-of-network charge	$135 Copayment plus difference between the network cost and the out-of-network charge

Once your total drug costs reach $2,250, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay or your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

continued

Coverage after you reach your initial coverage limit and before you qualify for catastrophic coverage

After your total drug costs reach $2,250, you or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $3,600, and you qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,600 out-of-pocket for the year. When the total amount you have paid toward copayments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of a $2 copayment for generics or preferred brand name drugs that are multi-source drugs and a $5 copayment for all other drugs, or 5% coinsurance. We will pay the rest.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by a Medicare Prescription Drug Plan, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

- Your coinsurance or copayments made on drugs normally covered in a Medicare Prescription Drug Plan that are:
  - Covered by the Plan up to the initial coverage level,
  - Not on our Plan's formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions or appeals process; and
  - Filled at an out-of-network pharmacy in accordance with our Plan's out-of-network access rules.
- Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.

*Purchases that will **not** count toward your out-of-pocket costs:*

– Prescription drugs purchased outside the United States and its territories;

– Prescription drugs not covered by the Plan.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for prescription drugs normally covered by a Medicare Prescription Drug Plan count toward your out-of-pocket costs and will help you qualify for catastrophic coverage.

In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

– Family members or other individuals;

– Qualified State Pharmacy Assistance Programs (SPAPs);

– Medicare programs that provide extra help with prescription drug coverage; and

– Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

*Payments made by the following do **not** count toward your out-of-pocket costs:*

– Group Health Plans;

– Insurance Plans and government funded health programs (e.g., TRICARE, the Indian Health Service); and

– Third-party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation).

If you have coverage from a third-party that pays a part of or all of your out-of-pocket costs, you must disclose this information to us. An example of third-party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

continued

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
  - ***Amount Paid for Prescriptions—***
    The amounts paid that count towards your initial coverage limit.
  - ***Out-of-Pocket Payments after You Reach the Initial Coverage Limit—***
    The amount you and/or others make after you reach the initial coverage limit and before you qualify for catastrophic coverage.
  - ***Total Out-of-Pocket Costs that Count Towards Catastrophic Coverage—***
    The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your copayments and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

When will you get your Explanation of Benefits?

You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us.

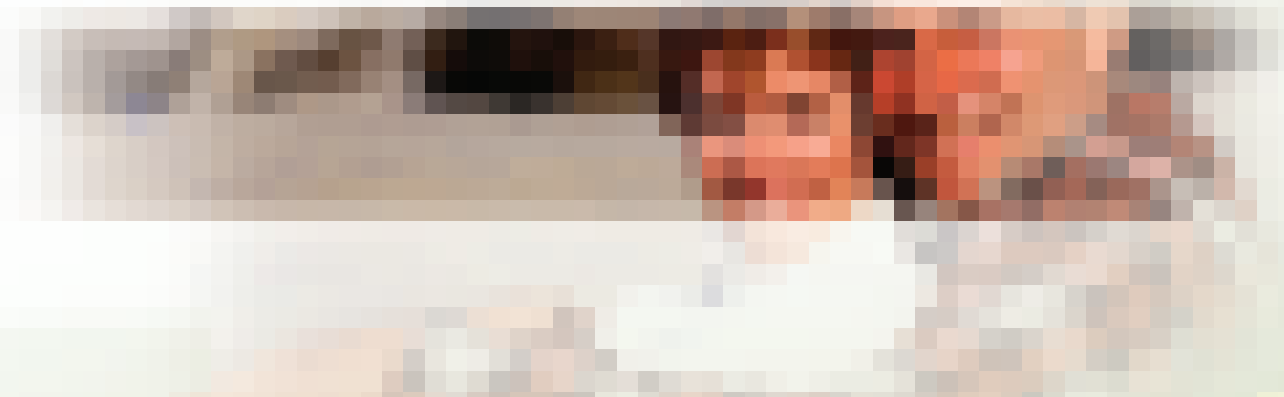
What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.



We will send you a CMS Secondary Payer Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your copayments. Please contact your SPAP to determine what benefits are available to you.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy **that includes coverage for prescription drugs,** you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

If you are a member of an employer or retiree group

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group.

In the fall of 2005, your employer or retiree group sent a letter that indicated whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not get this letter, please contact your benefits administrator.

If you are enrolled in a Medicare-approved drug discount card program

If you have a Medicare-approved drug discount card, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are enrolled in a non-Medicare-approved drug discount card program

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and covered by us can count towards your out-of-pocket expenses. Contact Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., for a claim form. Follow the instructions printed on the claim form.

continued

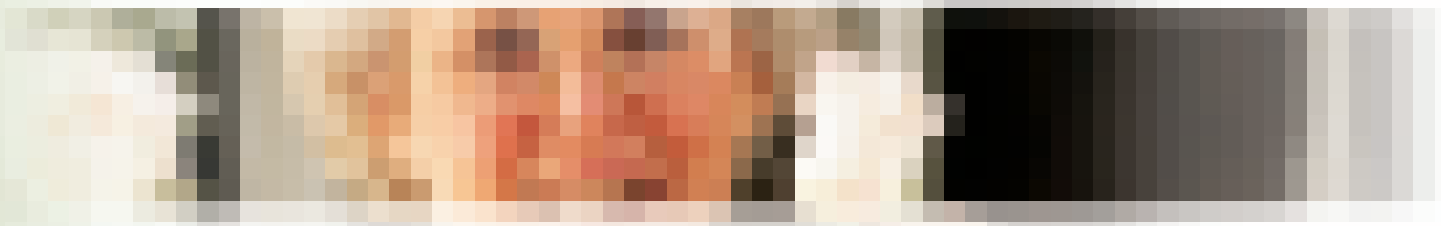
What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Customer Service numbers listed on the cover.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations and appeals.



What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower copayment. If you request an exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part of Section 6 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

– You feel that you are being encouraged to leave (disenroll from) our Plan.

– Problems with the customer service you receive.

– Problems with how long you have to spend waiting on the phone or in the pharmacy.

– Disrespectful or rude behavior by pharmacists or other staff.

– Cleanliness or condition of pharmacy.

– If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.

– You believe our notices and other written materials are difficult to understand.

– Failure to give you a decision within the required timeframe.

– Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.

– Failure by the plan sponsor to provide required notices.

– Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Customer Service at the numbers listed on the cover. **We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the BlueRx Part D Grievance Procedure.**

continued

The BlueRx Fast-Track Grievance Procedure is as follows:

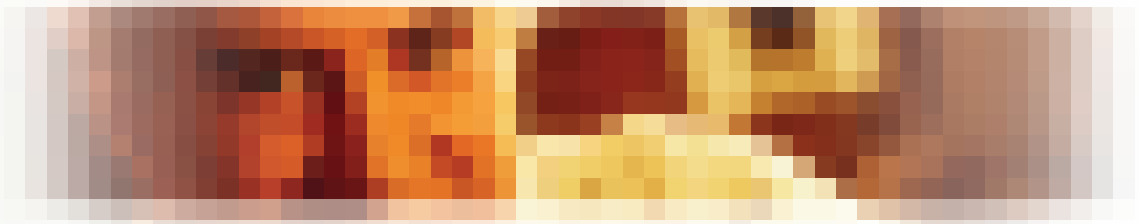
The fast-track grievance procedures are used in the following instance:

– If you disagree with the decision made by Highmark BlueRx not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the BlueRx Customer Service department. You may call 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m. Outside these hours, please call 1-800-485-9610 (TTY users, call 1-888-422-1226).

– You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest.

– Highmark will review your complaint and take the appropriate steps to investigate your complaint. Highmark will respond in writing within 24 hours from the date the BlueRx Grievance department receives your complaint.



The BlueRx Standard Grievance Procedure is as follows:

– Your initial inquiry should be directed to the BlueRx Customer Service department. If you are dissatisfied with the response to your inquiry, you can ask for a First Level Complaint Review. Your complaint for review should be made in writing. Your written complaint may include written information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests in writing.

Send your written complaint to:

Highmark BlueRx Appeals and Grievance Department
P.O. Box 535047
Pittsburgh, PA 15253-5074
Fax # 1-412-544-1513

– Highmark will review your written complaint. For complaints regarding such issues as waiting times, pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, Highmark will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the pharmacy provider, a review of the medical records or ongoing provider monitoring. Highmark will respond in writing within 30 days or as expeditiously as the case requires.

– Complaints that do not involve pharmacy providers or general dissatisfaction with the Part D plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 days or as expeditiously as the case requires. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 days from the date the decision is received and may include any written supporting material from you or any party of interest.

– The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee member will not be a Highmark employee, but they must be a member of a Highmark health care plan. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Highmark will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the Committee. The hearing will be held within 30 days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.

– The decision of the Second Level Complaint Committee will be binding.

– For further information regarding the purposes and operations of the grievance procedure, contact Highmark BlueRx Customer Service.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare Prescription Drug Plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

continued

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part of Section 6 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a coverage determination.

The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by us.
- If you have received a Part D prescription drug you believe may be covered by us while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the copayment we require you to pay for a drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled, "Detailed information about how to request a coverage determination and an appeal".

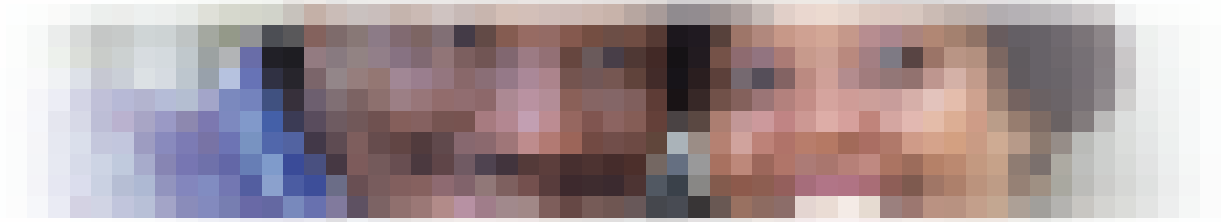
How to request an appeal

This part of Section 6 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request (described in Section 4 of this document), you can appeal. A coverage determination, which includes those described on page 45, may be appealed if you disagree with our decision.

Note: *If we approve your exception request for a non-formulary drug, you cannot request an exception to the copayment we require you to pay for the drug.*



How does the appeals process work?

There are five levels to the appeals process.

Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

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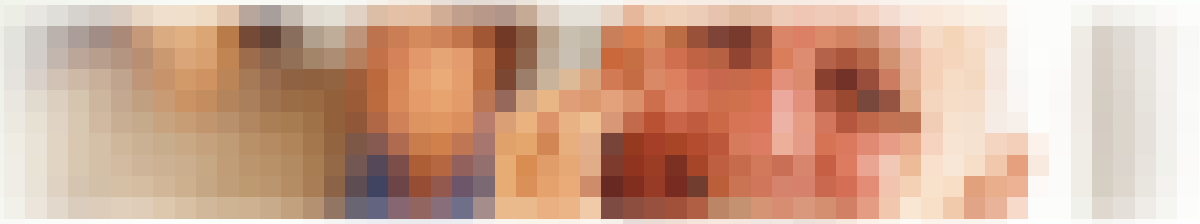
Each appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal."



Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage determinations—*Our Plan makes a coverage determination about your Part D prescription drug, or about paying for a Part D drug you have already received*

What is a coverage determination?

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact our Plan and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" our decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

– You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service to get help in making this request.

– You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can refer to our Customer Service to ask for this type of decision.

– You ask for an exception to our plan's utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call Customer Service to ask for this type of decision.

– You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can refer to our Customer Service to ask for this type of decision.

– You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the Plan. See Section 1 for a description of these circumstances. You can refer to our Customer Service to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a doctor's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by our Plan).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at BlueRx Member Service Department, P.O. Box 890388, Camp Hill, PA 17089. You can call Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

continued

Asking for a "Standard" or "Fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Customer Service numbers listed on the cover and in the Introduction section for assistance. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546. Be sure to ask for a "fast," "expedited" or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

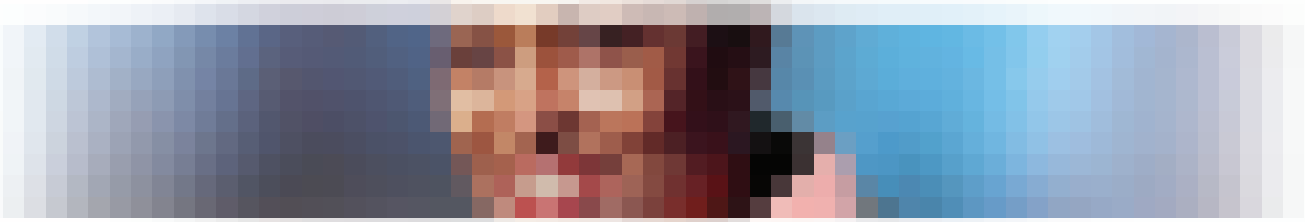
If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**



We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast coverage determination about a Part D drug that you have not received.*

   If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review — sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

continued

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72-hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

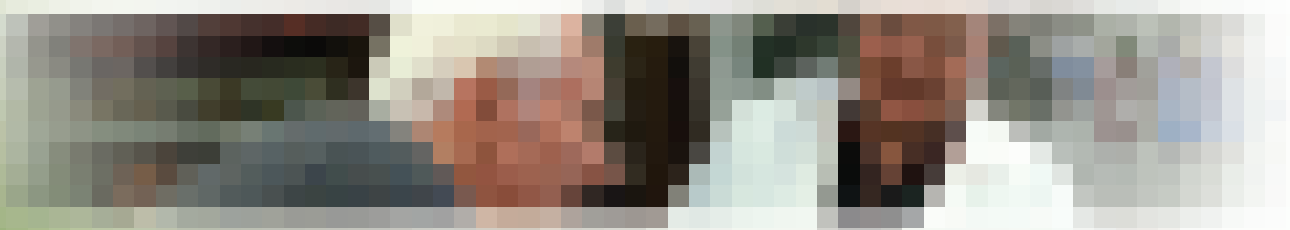
   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. *For a fast decision about a Part D drug that you have not received.*

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).



Appeal Level 1—*If we deny all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."*

Please call Customer Service if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision." While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different — please refer to "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

In writing: *BlueRx Appeals and Grievance Department*
P.O. Box 535047
Pittsburgh, PA 15253-5047.

By fax, at ***1-412-544-1513***.

By telephone *— if it is a fast appeal — at 1-800-485-9610; TTY users—1-888-422-1226*.

continued

In person, at any of the following walk-in centers:

– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-800-290-3914 (TTY users, call 1-800-988-0668) or write us at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your appeal?

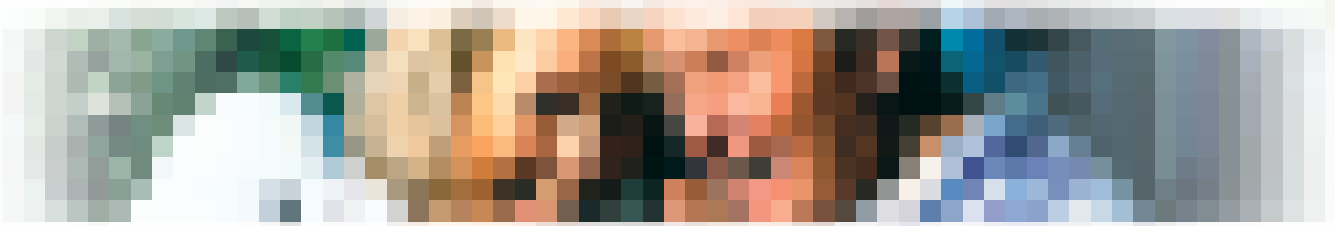
You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to BlueRx Expedited Review Department,

P.O. Box 535073, Pittsburgh, PA 15253-5073 or fax it to 1-800-894-7947. For requests that are made outside of regular weekday business hours, call BlueRx Expedited Review at 1-800-485-9610 (TTY users, call 1-888-422-1226). Be sure to ask for a "fast," "expedited" or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. *While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Send your standard appeal requests to BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047. Send your expedited appeal requests to BlueRx Expedited Review Department, P.O. Box 535073, Pittsburgh, PA 15253-5073.*



How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

   After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

   After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must send payment to you no later than 30 calendar days after we get your request to reconsider our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

continued

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

Appeal Level 2—*If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization*

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you — only you or your appointed representative may file the request.

If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.*
2. *For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.*

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must pay within 30 calendar days from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

continued

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110.00 or more.

Appeal Level 3—*If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge*

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to Department of Health and Human Services, Office of Medicare Hearings & Appeals, 200 Public Square, Suite 1300, Cleveland, OH 44114-2316.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110.00. If the dollar value is less than $110.00, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.
2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

continued

Appeal Level 4—*Your case may be reviewed by the Medicare Appeals Council*

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

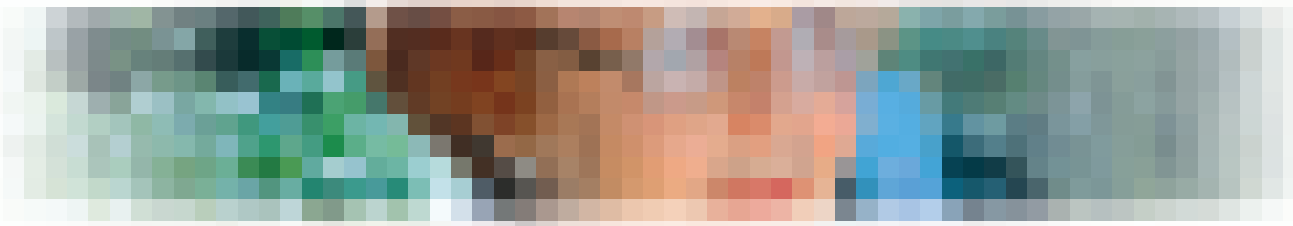
If the Council decides against you

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5— *Your case may go to a Federal Court*

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.



How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once we get notice of a judicial decision in your favor, *what happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you within 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge decides against you

The Judge's decision is final and you may not take the appeal any further.

What is "disenrollment"?

"Disenrollment" from our Plan means ending your membership with us. **Disenrollment can be** voluntary **(your own choice)** or, in limited circumstances, involuntary **(not your own choice):**

– You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (see "When Can You Disenroll/Switch Prescription Drug Plans?" below).

– There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you move out of our geographic service area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your Rx

If you leave our Plan, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can disenroll from your plan at other times. After you request to disenroll, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy or through our mail order pharmacy service, are listed on our formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Customer Service numbers listed on the cover and in the Introduction section.

continued

What are your options for getting Rx drug coverage if you leave our Plan?

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage *if* this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage. If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must get your Medicare prescription drug coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

You may also be able to get back the prescription drug coverage you had before you enrolled in our Plan. Please contact your previous Prescription Drug Plan for more information.

Note: *If you disenroll from our Plan and do not enroll in another Medicare Prescription Drug Plan, or have other prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a penalty if you enroll in a Medicare Prescription Drug Plan at a later date. Refer to Section 3 for more information on the penalty.*

When can you disenroll/switch Medicare Prescription Drug Plans?

In general, you may only disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances.

You can switch your Prescription Drug Plan during the following periods:

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006), you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you did not get this letter, contact the issuer of your Medigap policy.

Annual Coordinated Election Period

During the Annual Coordinated Election Period, anyone with prescription drug coverage may disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare prescription drug coverage.

For coverage beginning in 2006, the annual coordination election period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the annual coordinated election period goes from November 15 through December 31 of each year.

Please remember, if during this election period you disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare prescription drug coverage in the future.

If you join another Prescription Drug Plan during the annual coordinated election period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

Exception for January 1, 2006 through May 15, 2006: If you disenroll from our Plan to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

continued

Special Enrollment Period

Generally, you may not disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year *unless* you qualify for a Special Enrollment Period.

In order to qualify for a Special Enrollment Period, one of the following must apply to you:

– Our Plan no longer offers prescription drug coverage in the area where you live.

– You move outside our Plan's service area.

– You have an involuntary loss of creditable prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.

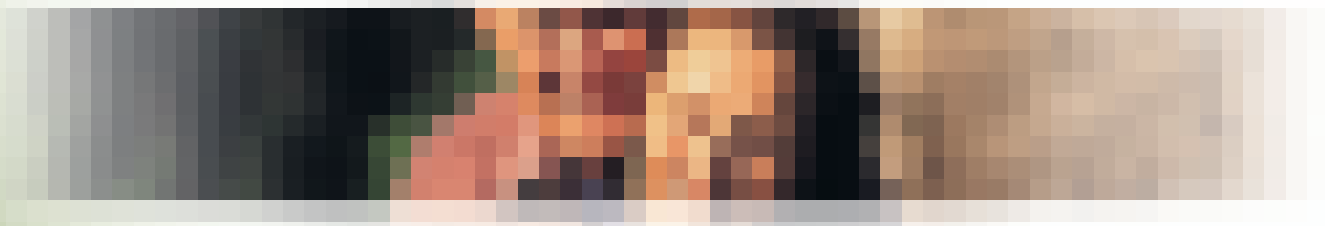
– You were not adequately informed about your loss of creditable prescription drug coverage, or you were not adequately informed that you never had creditable prescription drug coverage.

– Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.

– You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.

– Our Plan's contract with the Centers for Medicare & Medicaid Services is terminated.

– You were a member of a Medicare Advantage Plan with prescription drug coverage and decided to join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.



– You are able to demonstrate that our Plan has substantially violated a material provision in its contract. *This includes, but is not limited to:*

  – If our Plan failed to provide you with prescription drug coverage in a timely manner.

  – If our Plan failed to provide your prescription drug coverage with applicable quality standards.

  – You are able to demonstrate that our Plan misrepresented itself in its marketing.

– You are enrolling in or disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse's current or former employer.

– In certain cases in which the Plan is sanctioned by the Centers for Medicare & Medicaid Services.

– You enroll in or disenroll from your state's Program of All-Inclusive Care for the Elderly.

– You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.

– You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.

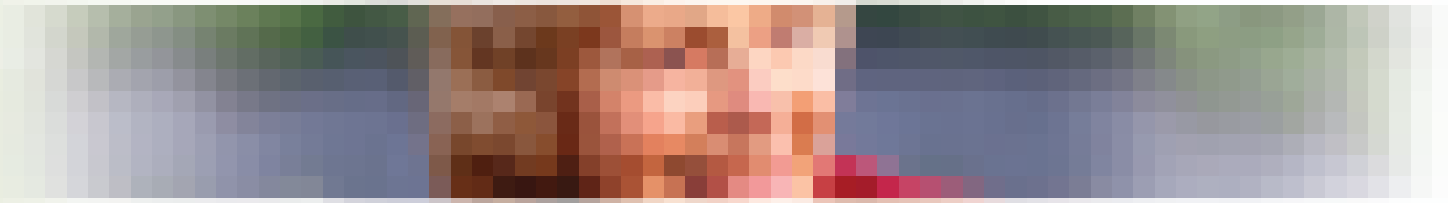
In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Service and we will assist you.

How do you disenroll?

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a disenrollment request. Your request should include your name, Medicare number, Social Security number, date of birth, and requested disenrollment date. (Please note that we may not be able to disenroll you on the date you request.) Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can mail a letter to us at BlueRx Enrollment Department, P.O. Box 535049, Pittsburgh, PA 15253-5049 or fax it to us at 1-412-544-2111. You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

continued

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your "disenrollment date"). Remember, you are still a member of our Plan until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.



When can the Plan disenroll you?

Our Plan can disenroll you for the following reasons:

– You are no longer eligible for Medicare prescription drug coverage.

– If our Plan is no longer contracting with Medicare or leaves your service area.

– When you move out of our Plan's service area.

– You materially misrepresent third-party reimbursement.

– You fail to pay your Plan premium.

– You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.

If you are no longer eligible for Medicare prescription drug coverage

If you lose your eligibility for Medicare prescription drug coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan's service area.

When the Plan is no longer contracting with Medicare or leaves your service area

If we leave the Medicare program or no longer offer prescription drug coverage in the service area where you live, we will notify you in writing. If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's network pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan. (See "When Can You Disenroll/Switch Prescription Drug Plans?" on page 64 for specific information on special enrollment periods.)

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When you move out of our Plan's service area

If you plan to move, please call our Customer Service numbers listed on the cover and in the Introduction section to find out if the place you are moving to is in our Plan's service area. If you move permanently out of our service area, you will need to leave ("disenroll" from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

You materially misrepresent third-party reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third-party reimbursement, our Plan has the right to decline you future enrollment in our Prescription Drug Plan.

continued

You fail to pay the Plan premium

If you fail to pay your Plan premium, our Plan has the right to disenroll you. Our Plan will send you a written notice in an effort to collect the unpaid premiums. Failure to comply with payment will result in disenrollment from the Plan.

In addition, if you are disenrolled from Plan for failure to pay your premium, Plan has the right to decline your future enrollment in our Prescription Drug Plan until your debt has been paid.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as standard Medicare prescription drug coverage for 63 days or longer, then you will pay a penalty the next time you enroll in a Medicare Prescription Drug Plan.

You engage in disruptive behavior, provide fraudulent information when you enroll or abuse your enrollment card

You may be asked to leave our Plan in the following circumstances:

– If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are members of our Plan. We cannot make you leave (i.e., disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.

– If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.

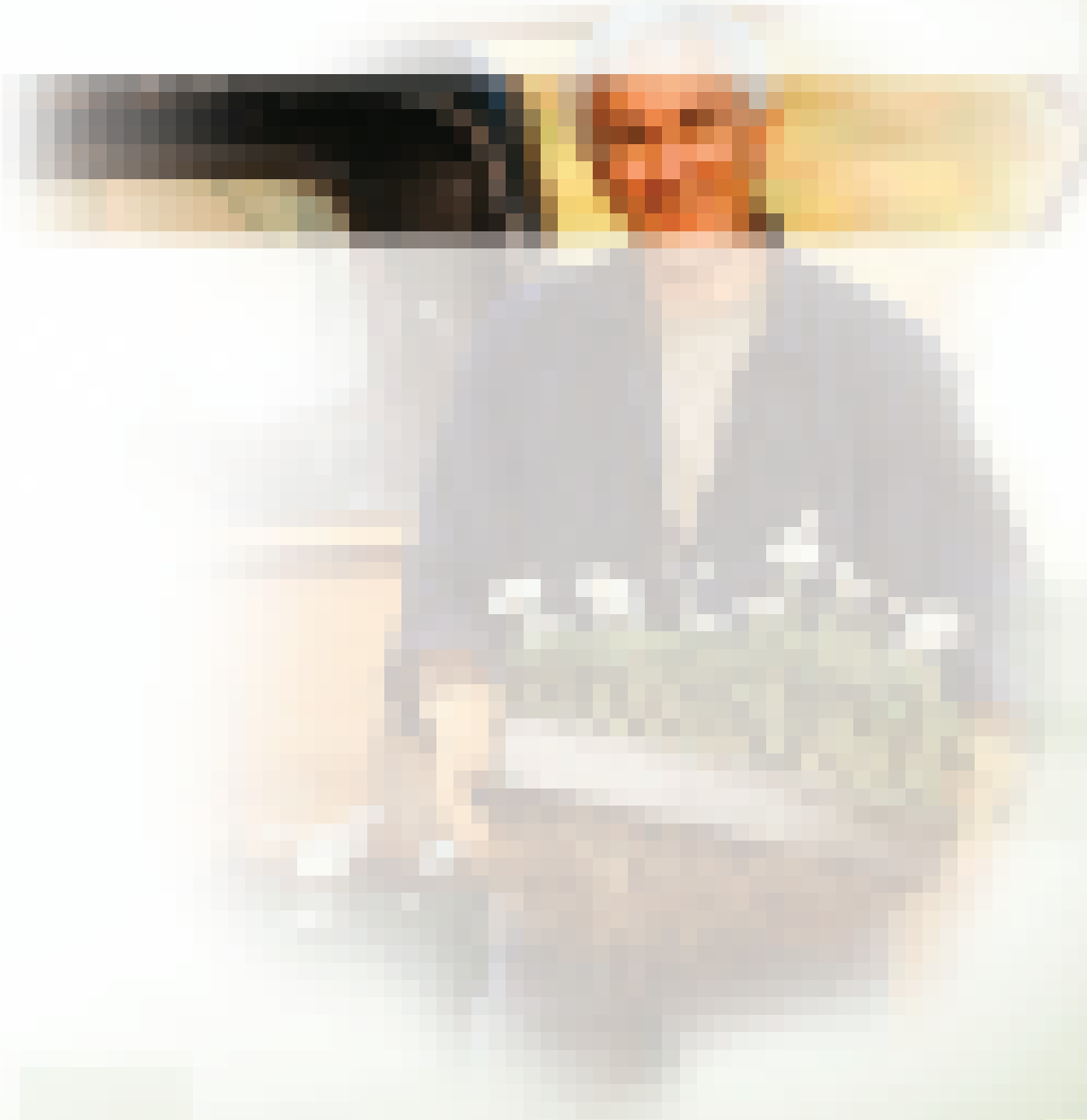
– If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We cannot ask you to leave our Plan because of your health

No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our Plan

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.



Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area:

Office for Civil Rights, Philadelphia Office
U.S. Dept. of Education
Wanamaker Building
100 Penn Square East, Suite 515
Philadelphia, PA 19107-3323
Telephone: 1-215-656-8541
Fax: 1-215-656-8605

If you need help with communication, such as help from a language interpreter, please call our Customer Service numbers listed on the cover.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

continued

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Customer Service numbers listed on the cover.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a network pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 6.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 6.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* us in the past. To get this information, call our Customer Service numbers listed on the cover.

Your right to get information about your drug coverage and costs

This Evidence of Coverage tells you what you have to pay for prescription drugs as a member of the Plan. If you need more information, please call our Customer Service numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about Highmark Senior Resources Inc. and BlueRx Plans. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone number listed on the cover.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Service numbers listed on the cover and in the Introduction section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction, page 10, tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

continued

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Service numbers listed on the cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

What are your responsibilities as a member of our Plan?

Along with the rights you have as a member of our Plan, you also have some responsibilities.

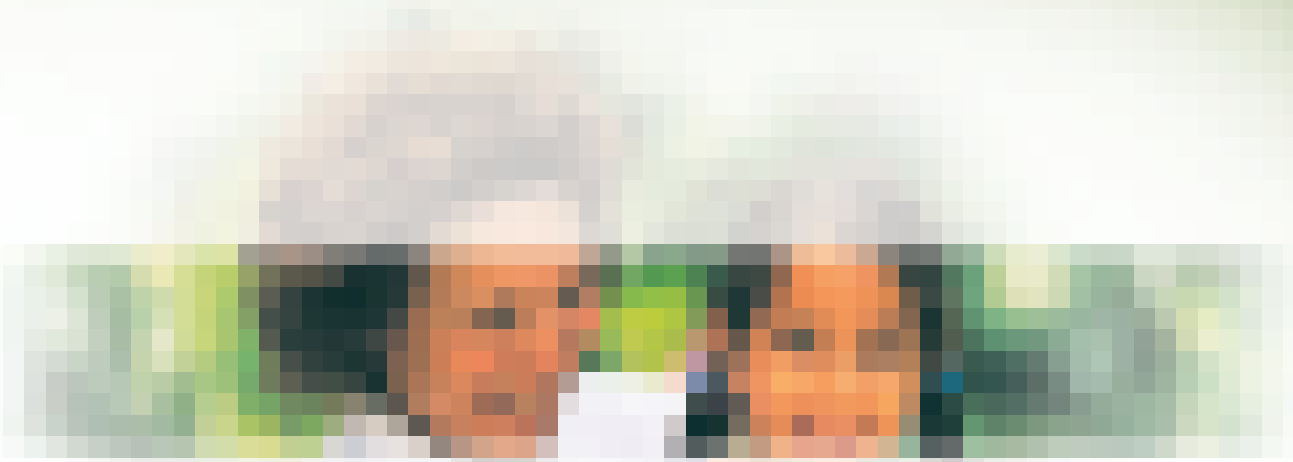
Your responsibilities include the following:

– Become familiar with your coverage and the rules you must follow to get care as a member. You can use this Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone numbers listed on the cover if you have any questions.

– Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

– Pay your plan premiums and any copayments you may owe for the covered drugs you get. You must also meet your other financial responsibilities that are described in Section 3.

– Let us know if you have any questions, concerns, problems or suggestions. If you do, please call our Customer Service numbers listed on the cover.



Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of your state may also apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like us, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

For the terms listed below, this section either gives a definition or directs you to a place in this Evidence of Coverage that explains the term

Appeal – A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug. Section 6 explains what appeals are, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are sometimes not available until after the patent on the brand-name drug has expired. Section 4 explains Plan coverage for brand name drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination – The decision the Plan makes about the prescription drug benefits you are entitled to get under the plan, and the amount that you are required to pay for a drug. Section 6 discusses these decisions.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan. Section 4 tells you what drugs are covered by BlueRx.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage. Section 5, "If you are a member of an employer or retiree group" mentions creditable coverage.

Customer Service – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact Customer Service.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses disenrollment.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception). See Section 6.

Formulary – A list of covered drugs provided by the plan. Section 4 talks about our formulary.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Section 4 explains Plan coverage for generic drugs.

Grievance - A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about grievances.

Late Enrollment Penalty – If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium. See Section 3.

Medically Necessary – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor. See Section 4.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). See Introduction.

continued

Medicare Advantage Plan with Prescription Drug Coverage – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. See Section 7.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. See Section 1.

"Medigap" (Medicare supplement insurance) Policy – Many people who have Original Medicare also buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage. See Section 5.

Member (member of our Plan) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS). See Section 5.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. See Section 1.

Non-preferred Brand Name Drug – A brand name drug that is not included on the preferred drug listing. BlueRx Plus provides coverage for these drugs, but at a lower benefit level (you pay higher cost-sharing). See Section 4.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

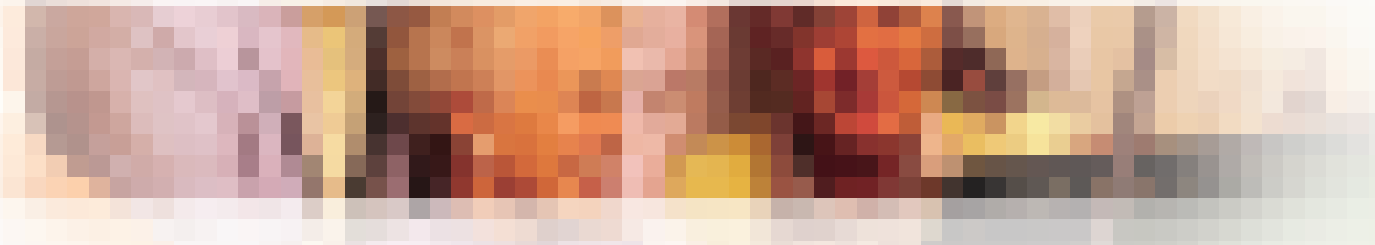
Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug unless it is covered under Part A or Part B. See Section 4.

Preferred Brand Name Drug – A brand name drug that is included on the preferred drug listing. BlueRx Plus provides coverage for these drugs at the higher benefit level (you pay lower cost-sharing). See Section 4.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some services are covered only if your doctor or other plan provider gets "prior authorization" from us. Covered services that need prior authorization are marked in the formulary. See Section 4.

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan. See Section 1.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. See Section 2.



A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

23170 (2-06) 23M

Evidence of Coverage

January 1st through
December 31

This Evidence of Coverage gives the details about your Medicare prescription drug coverage. It is an important legal document. Please keep it in a safe place.

Highmark Senior Resources
BlueRx Customer Service

For help or information, please call Customer Service Monday through Friday, 8:00 a.m. to 4:30 p.m. Calls to these numbers are free:

1-800-290-3914
TTY/TDD 1-800-988-0668
www.highmarkblueshield.com

HIGHMARK® BlueRx℠

A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

Highmark Blue Shield and Highmark Senior Resources are Independent Licensees of the Blue Cross and Blue Shield Association

S5593_05_079a (02/2006)
Contract Number S5593

Introduction: Welcome to BlueRx Complete

Section 1: Plan Basics

Section 2: Extra Help with Drug Plan Costs for People with Limited Income and Resources

Section 3: Monthly Premium

continued

Section 4: Prescription Drug Coverage

Section 5: If You Have Other Prescription Drug Coverage

Section 6: Appeals And Grievances: What To Do If You Have Complaints

continued

Section 7: Leaving this Plan and Your Choices for Continuing Prescription Drug Coverage after You Leave

Section 8: Your Rights and Responsibilities as a Member of this Plan

Section 9: Legal Notices

Section 10: Definitions of Some Words Used in This Evidence of Coverage

Welcome to BlueRx!

We are pleased that you've chosen our Plan

BlueRx Complete is a Medicare Prescription Drug Plan

Now that you are enrolled in BlueRx Complete, a Medicare Prescription Drug Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield.

Throughout the remainder of this Evidence of Coverage, we refer to BlueRx Complete as the "Plan."

This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our Plan

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. It also explains our responsibilities to you. The information in this Evidence of Coverage is in effect for the time period from January 1, 2006, through December 31, 2006.

This Evidence of Coverage gives you the details, including:

- What is covered in our Plan and what is not covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, including your choices for continuing Medicare prescription drug coverage.
- If you need this Evidence of Coverage in a different format (such as CDs or audiotapes), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time — your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

continued

How to contact our Plan's Customer Service

If you have any questions or concerns, please call or write to Customer Service. We will be happy to help you. Our business hours are Monday through Friday between 8:00 a.m. and 4:30 p.m.

CALL ***1-800-290-3914***. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

TTY/TDD ***1-800-988-0668***. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

WRITE ***BlueRx Member Service:***
– P.O. Box 890388
Camp Hill, PA 17089

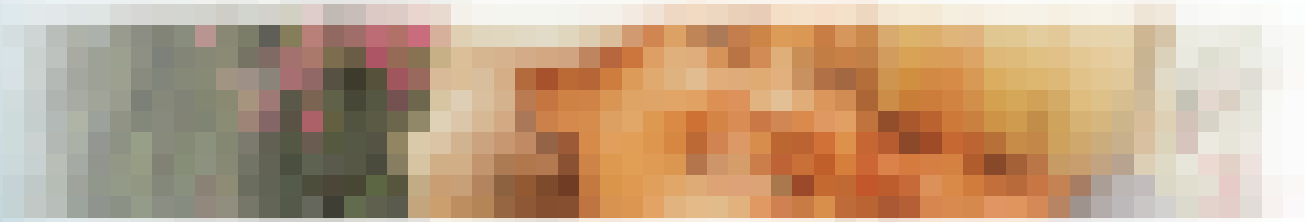
VISIT ***Our Customer Service Centers:***
– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106



How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Pennsylvania and West Virginia State Health Insurance Programs (SHIP)— *organizations in your state that provide free Medicare help and information*

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Prescription Drug Plans, Medicare Health Plans, and about Medigap (Medicare supplement insurance) policies.

You can find contact information for the SHIP in your state below. You can also find the Web site for your local SHIP at www.medicare.gov.

– **If you live in Pennsylvania**, you can contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m.

– **If you live in West Virginia**, contact the West Virginia Bureau of Senior Services at 1-304-558-3317,
1900 Kanawha Boulevard,
East Holly Grove, Building #10
Charleston, WV 25305-0160

continued

Pennsylvania and West Virginia QIO/Quality Improvement Organizations—*a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare*

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in the QIO review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can find contact information for the QIO in your state below.

– **If you live in Pennsylvania**, contact:
Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-800-322-1914

– **If you live in West Virginia**, contact:
West Virginia Medical Institute
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686

Other organizations

Medicaid agency — a state government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact the following state Medicaid program:

– **If you live in Pennsylvania**, contact:
Pennsylvania Dept. of Public Welfare
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462

– **If you live in West Virginia**, contact:
West Virginia Dept. of Health and Human Services
350 Capitol Street, Room 251
Charleston, WV 25301-3709
1-304-558-1700

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits, you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums or the open enrollment season.

What is BlueRx Complete?

BlueRx Complete is offered by Highmark Senior Resources Inc., a subsidiary of Highmark Blue Shield, and is a Medicare Prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare prescription drug coverage through Highmark Senior Resources. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare prescription drug coverage

Medicare prescription drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other coverage rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay your monthly premium and pay applicable copayments and coinsurances. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. If you have limited income and resources, you may get extra help from Medicare to pay your premium, copayments and coinsurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Service to learn more.

Help us keep your membership record up-to-date

We have a file of information about you as a Plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or from your current or former employer, or your spouse's current or former employer. In addition, you should tell Customer Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

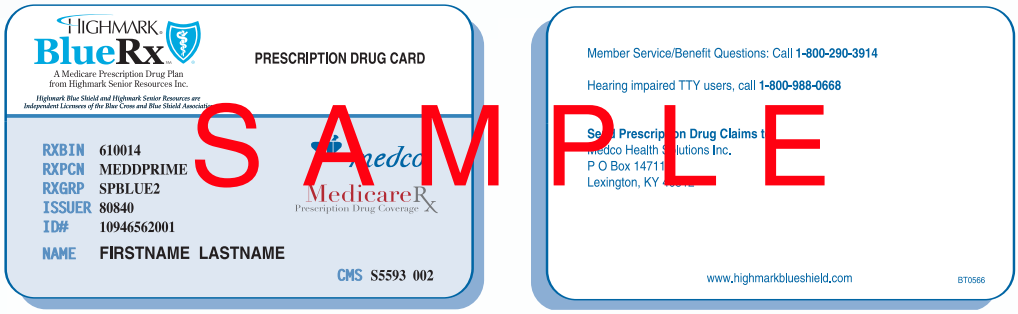
continued

What is the geographic service area for our Plan?

The states in our service area are listed below.
– Pennsylvania and West Virginia

Use your Plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of our Plan, you have a Plan membership card. *Here is a sample card to show what it looks like:*



During the time you are a plan member and using plan services, you *must* use your Plan membership card at network pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost or stolen, call Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered**.

– ***What is a "network pharmacy"?***

A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

– ***What are "covered drugs"?***

"Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies

As a member of our Plan, we will send you a BlueRx Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do I fill a prescription through the Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a one-day supply, and no more than a 90-day supply of the drug.

continued

Generally, it takes us eight days to process your order and ship it to you. However, sometimes your mail order may be delayed. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering through our mail order service. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail order prescription is being processed.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Filling prescriptions outside the network

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription.** If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

- When you are traveling outside your Plan's service area and you run out of or lose your covered Part D drugs, or you become ill and need a covered Part D drug, and you cannot access a network pharmacy.
- You are not able to obtain a covered Part D drug in a timely manner within your service area because, for example, there is no network pharmacy within a reasonable driving distance that provides service 24 hours a day, seven days a week.
- Filling a prescription for a particular covered Part D drug (for example, an orphan drug or other specialty pharmaceutical) that is not regularly stocked at an accessible network retail or mail order pharmacy.
- The provided covered Part D drug is dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

BlueRx will reimburse you for our share of the cost of any covered Part D prescription drug you purchase from an out-of-network pharmacy; however, when you use an out-of-network pharmacy, you are responsible for paying the difference between the out-of-network price and the network pharmacy price *plus* your applicable network copayment or coinsurance.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Call BlueRx Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., and request a paper claim form. Mail your completed claim form along with your prescription drug receipts to the address printed on the form.

Specialty pharmacies

Home infusion pharmacies

The Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Service.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary and are covered by our Plan, but are not already covered by Medicare Part B. In addition, we cover some drugs that may be administered in your doctor's office. (Please see Section 4, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B," for more information.)

What extra help is available?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium and prescription copayments and coinsurances.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: *Amounts shown above are for 2006. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Customer Service to find out what the income limits are.*

Some people automatically qualify for extra help and do not have to apply for it.

If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the cover and in the introduction section. Or, visit our Web site.

Please Note: *If you are receiving extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your Evidence of Coverage Rider.*

Paying the plan premium for your coverage as a member of our Plan

How much is your monthly plan premium and how do you pay it?

In BlueRx Complete, you must pay a $47.46 premium each month.

If you get your benefits from your current or former employer or from your spouse's current or former employer, call the employer's benefits administrator for information about your plan premium.

There are two ways to pay your monthly plan premium.

– ***Option One:***

Pay your plan premium directly to our Plan.

Monthly invoices for your BlueRx premiums will be mailed on or about the 12th day of each month. Your payment is due on the 1st day of the following month. For example, your bill for February coverage will be mailed on or about January 12 and is due on February 1. You may pay your monthly premium by check or money order (no cash), made payable to "Highmark Senior Resources." Mail your payment to: Highmark Blue Shield, P.O. Box 382057, Pittsburgh, PA 15250-8057. If you prefer, you can drop off your payment in person at any of the Customer Service centers listed in the Introduction section.

If you prefer, you can also have your premium automatically withdrawn from your bank account. This automatic premium payment program, called "Pay-It-Easy," is easy to set up and convenient to use. Simply call Customer Service and request an application. Automatic deductions are made monthly on the 1st day of each month.

– ***Option Two:***

You can have your monthly plan premium directly deducted from your monthly Social Security check. You can choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact Customer Service for more information on how to pay your premium this way.

Note: *If you choose to have your premium deducted from your Social Security check, we will only collect the premium amounts listed below, due to a minor computer processing issue. The small difference indicated in the table below requires no action on your part, absent further notice.*

States in Service Area	Rounded Down Premium	Total Yearly Difference
Pennsylvania and West Virginia	$47.40	$0.72

If you have any questions about your plan premiums or the different ways to pay them, please call our Customer Service numbers listed on the cover and in the Introduction section.

continued

What happens if you don't pay your plan premiums, or don't pay them on time?

If your plan premiums are past due, we will tell you in writing when a 60-day grace period begins. Failure to pay your past-due plan premiums within the 60-day grace period will result in your disenrollment. Disenrollment ends your membership in our Plan. If you are disenrolled, you will not be able to enroll in another Medicare Prescription Drug Plan until the next Annual Coordinated Election Period, unless you qualify for a Special Enrollment Period. If you do not qualify for a Special Enrollment Period or have another source of creditable prescription drug coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

Please see Section 7 or call Customer Service to find out more about enrollment periods.

Can your plan premiums change during the year?

Generally, your plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1, 2007.

In limited circumstances, your plan premium may change during the calendar year. If you aren't currently receiving extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. The Social Security Administration or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help.

Do you have to continue to pay your Part A or Part B premiums?

To be a member of our Plan, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our service area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this Plan.

Some members who belong to a Medicare Savings Program (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. Please see Section 2 or call Customer Service for more information.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty in addition to your monthly plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the late enrollment penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

This section describes your prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

continued

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions" later in this section for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 ("Plan Basics") for more information about filling prescriptions at out-of-network pharmacies.

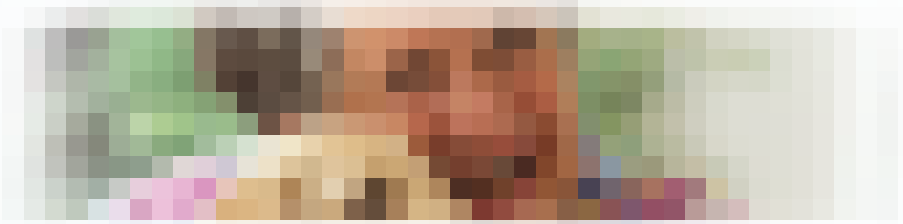
How do you find out what drugs are on the formulary?

You may call Customer Service to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your copayment depends on which drug tier your drug is in. The table below shows the copayment amount you pay for each tier when you are in your initial coverage level. (See "How Much Do You Pay for Drugs Covered by this Plan?" on page page 32 of this document for more information about the initial coverage level.)

You can ask us to make an exception to your drug's tier placement. See Section 6 to learn more about how to request an exception.



Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations or quantity limits on a drug, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60 days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Customer Service to be sure it is not covered. *If Customer Service confirms that we do not cover your drug, you have three options:*

– You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service.

– You can ask us to make an exception to cover your drug. See Section 6 to learn more about how to request an exception.

– You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting a formulary exception. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 6 for more information on how to request an appeal.

If you recently joined this Plan and learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. *You can get a one-time fill of the non-covered drug if one of the following applies:*

– You didn't know that your drug wasn't covered by this Plan, or

– You knew it wasn't covered but you didn't know that you could request an exception to the Plan's formulary.

After your one-time fill, you can ask Customer Service if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See Section 6 to learn more about how to request an exception.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment.

The Highmark Medicare-approved Choice Formulary includes a comprehensive list of medications designed to meet the needs of our members. Still, we want to make every effort to ensure that new and existing members experience a smooth transition into their prescription drug benefits in 2006 and beyond.

If you are currently taking a medication that is not included in the Highmark Medicare-approved Choice Formulary, you or your doctor may request a tier exception for coverage of that medication at the brand copayment instead of the non-formulary brand copayment. You may ask us for this exception before enrolling in the Plan to determine if your medication will be covered at the brand copayment. You received a short version of the formulary list in your BlueRx enrollment materials. The entire formulary is available by calling Customer Service or visiting our Web site www.highmarkblueshield.com.

continued

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. *These drugs or categories of drugs are called "exclusions" and include:*

Nonprescription drugs, unless they are part of an approved step therapy	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

Drug management programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. *Examples of utilization management tools are described below:*

- ***Prior Authorization:*** We require you to get prior authorization for certain drugs. This means that you or your prescribing physician will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- ***Quantity Limits:*** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to eight patches per prescription for Estraderm.
- ***Generic Substitution:*** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug. If you or your doctor request a brand name drug when a generic version is available, you will be responsible for paying the brand name copayment plus the difference in cost between the generic and brand name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See Section 6 to learn more about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. *During these reviews, we look for medication problems such as:*

– Possible medication errors

– Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition

– Drugs that are inappropriate because of your age or gender

– Possible harmful interactions between drugs you are taking

– Drug allergies

– Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

continued

We offer a medication therapy management program for members who meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

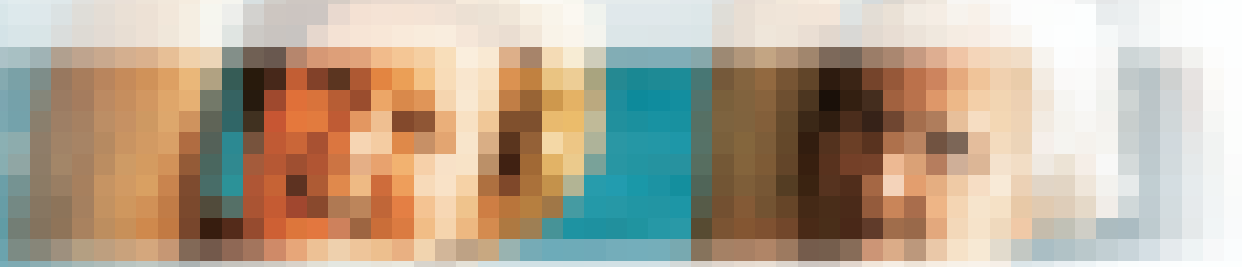
Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug is covered by Medicare Part A or Part B, it cannot be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases, but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2, "Extra Help with Drug Plan Costs for People with Limited Income and Resources," and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.



Initial coverage level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the **copayment**. Your copayment will vary depending on the drug and where the prescription is filled.

Drug Tier	Retail Copayment (34-day supply)	Retail Copayment (90-day supply)	Mail Order Copayment (90-day supply)	Out-of-Network Copayment (34-day supply)	Out-of-Network Copayment (90-day supply)
Formulary Generic	$8 Copayment	$24 Copayment	$20 Copayment	$8 Copayment plus difference between the network cost and the out-of-network charge	$24 Copayment plus difference between the network cost and the out-of-network charge
Formulary Brand Name	$20 Copayment	$60 Copayment	$50 Copayment	$20 Copayment plus difference between the network cost and the out-of-network charge	$60 Copayment plus difference between the network cost and the out-of-network charge
Non-Preferred Brand Name	$40 Copayment	$120 Copayment	$100 Copayment	$40 Copayment plus difference between the network cost and the out-of-network charge	$120 Copayment plus difference between the network cost and the out-of-network charge

Once your total drug costs reach $2,250, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay or your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

continued

Coverage after you reach your initial coverage limit and before you qualify for catastrophic coverage

After your total drug costs reach $2,250, we will continue to provide prescription drug coverage until your total out-of-pocket costs reach $3,600. You or others on your behalf will pay: an $8 copayment for each generic drug. If you purchase brand name drugs during this period, you will have to pay 100% of the Highmark discounted price. Once your total out-of-pocket costs reach $3,600, you will qualify for catastrophic coverage.

Catastrophic coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,600 out-of-pocket for the year. When the total amount you have paid toward copayments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of a $2 copayment for generics or preferred brand name drugs that are multi-source drugs and a $5 copayment for all other drugs, or 5% coinsurance. We will pay the rest.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is normally covered by a Medicare Prescription Drug Plan, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

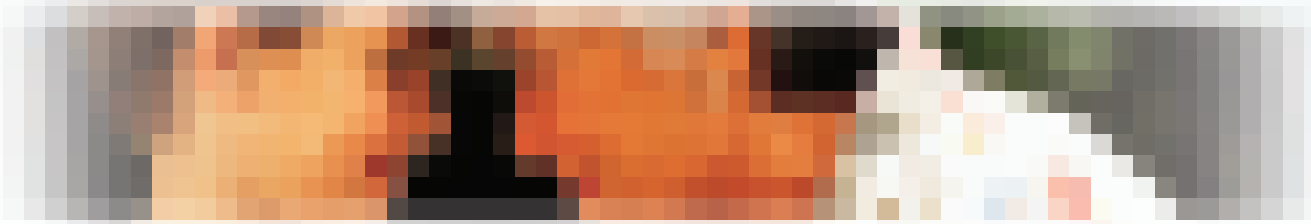
- Your coinsurance or copayments made on drugs normally covered in a Medicare Prescription Drug Plan that are:
  - Covered by the Plan up to the initial coverage level,
  - Not on our Plan's formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions or appeals process; and
  - Filled at an out-of-network pharmacy in accordance with our Plan's out-of-network access rules.
- Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.

*Purchases that will **not** count toward your out-of-pocket costs:*

– Prescription drugs purchased outside the United States and its territories;

– Prescription drugs not covered by the Plan.



Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for prescription drugs normally covered by a Medicare Prescription Drug Plan count toward your out-of-pocket costs and will help you qualify for catastrophic coverage.

In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

– Family members or other individuals;

– Qualified State Pharmacy Assistance Programs (SPAPs);

– Medicare programs that provide extra help with prescription drug coverage; and

– Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

*Payments made by the following do **not** count toward your out-of-pocket costs:*

– Group Health Plans;

– Insurance Plans and government funded health programs (e.g., TRICARE, the Indian Health Service); and

– Third-party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation).

If you have coverage from a third-party that pays a part of or all of your out-of-pocket costs, you must disclose this information to us. An example of third-party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

continued

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
  - ***Amount Paid for Prescriptions—***
    The amounts paid that count towards your initial coverage limit.
  - ***Out-of-Pocket Payments after You Reach the Initial Coverage Limit—***
    The amount you and/or others make after you reach the initial coverage limit and before you qualify for catastrophic coverage.
  - ***Total Out-of-Pocket Costs that Count Towards Catastrophic Coverage—***
    The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your copayments and coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

When will you get your Explanation of Benefits?

You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us.

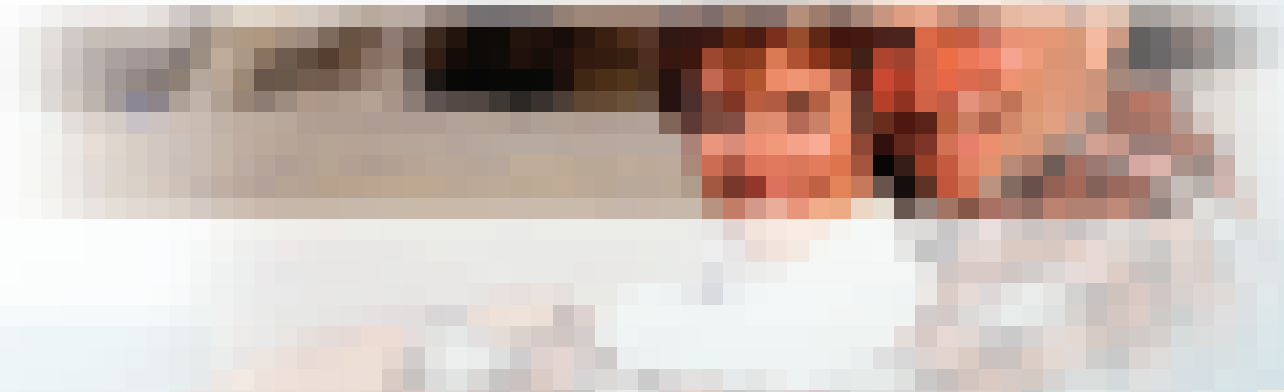
What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process. When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.



We will send you a CMS Secondary Payer Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your copayments. Please contact your SPAP to determine what benefits are available to you.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy **that includes coverage for prescription drugs,** you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

If you are a member of an employer or retiree group

If you currently have prescription drug coverage through your employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group.

In the fall of 2005, your employer or retiree group sent a letter that indicated whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not get this letter, please contact your benefits administrator.

If you are enrolled in a Medicare-approved drug discount card program

If you have a Medicare-approved drug discount card, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are enrolled in a non-Medicare-approved drug discount card program

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and covered by us can count towards your out-of-pocket expenses. Contact Customer Service at 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m., for a claim form. Follow the instructions printed on the claim form.

continued

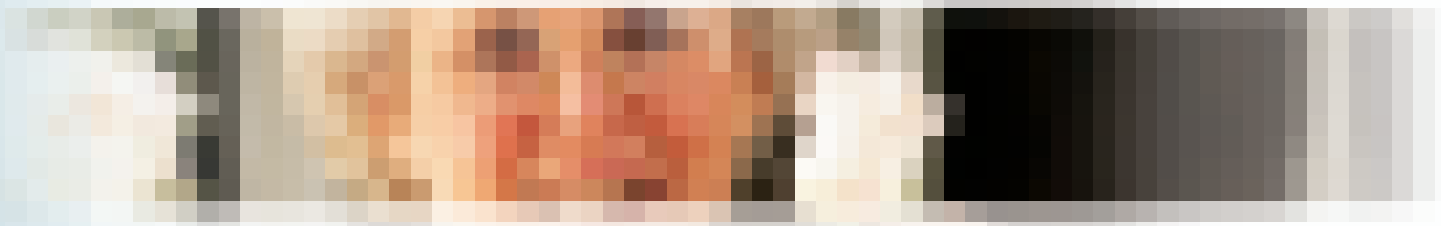
What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Customer Service numbers listed on the cover.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations and appeals.



What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower copayment. If you request an exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part of Section 6 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

– You feel that you are being encouraged to leave (disenroll from) our Plan.

– Problems with the customer service you receive.

– Problems with how long you have to spend waiting on the phone or in the pharmacy.

– Disrespectful or rude behavior by pharmacists or other staff.

– Cleanliness or condition of pharmacy.

– If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.

– You believe our notices and other written materials are difficult to understand.

– Failure to give you a decision within the required timeframe.

– Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.

– Failure by the plan sponsor to provide required notices.

– Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Customer Service at the numbers listed on the cover. **We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the BlueRx Part D Grievance Procedure.**

continued

The BlueRx Fast-Track Grievance Procedure is as follows:

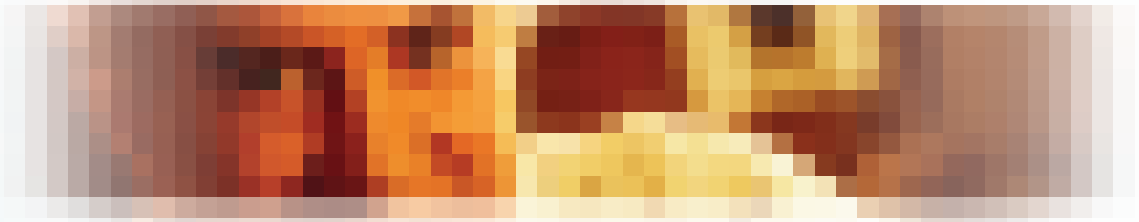
The fast-track grievance procedures are used in the following instance:

– If you disagree with the decision made by Highmark BlueRx not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the BlueRx Customer Service department. You may call 1-800-290-3914 (TTY users, call 1-800-988-0668), Monday through Friday, between 8:00 a.m. and 4:30 p.m. Outside these hours, please call 1-800-485-9610 (TTY users, call 1-888-422-1226).

– You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest.

– Highmark will review your complaint and take the appropriate steps to investigate your complaint. Highmark will respond in writing within 24 hours from the date the BlueRx Grievance department receives your complaint.



The BlueRx Standard Grievance Procedure is as follows:

– Your initial inquiry should be directed to the BlueRx Customer Service department. If you are dissatisfied with the response to your inquiry, you can ask for a First Level Complaint Review. Your complaint for review should be made in writing. Your written complaint may include written information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests in writing.

Send your written complaint to:

Highmark BlueRx Appeals and Grievance Department
P.O. Box 535047
Pittsburgh, PA 15253-5074
Fax # 1-412-544-1513

– Highmark will review your written complaint. For complaints regarding such issues as waiting times, pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, Highmark will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the pharmacy provider, a review of the medical records or ongoing provider monitoring. Highmark will respond in writing within 30 days or as expeditiously as the case requires.

– Complaints that do not involve pharmacy providers or general dissatisfaction with the Part D plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 days or as expeditiously as the case requires. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 days from the date the decision is received and may include any written supporting material from you or any party of interest.

– The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee member will not be a Highmark employee, but they must be a member of a Highmark health care plan. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Highmark will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the Committee. The hearing will be held within 30 days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.

– The decision of the Second Level Complaint Committee will be binding.

– For further information regarding the purposes and operations of the grievance procedure, contact Highmark BlueRx Customer Service.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare Prescription Drug Plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

continued

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part of Section 6 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a coverage determination.

The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by us.
- If you have received a Part D prescription drug you believe may be covered by us while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the copayment we require you to pay for a drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled, "Detailed information about how to request a coverage determination and an appeal."

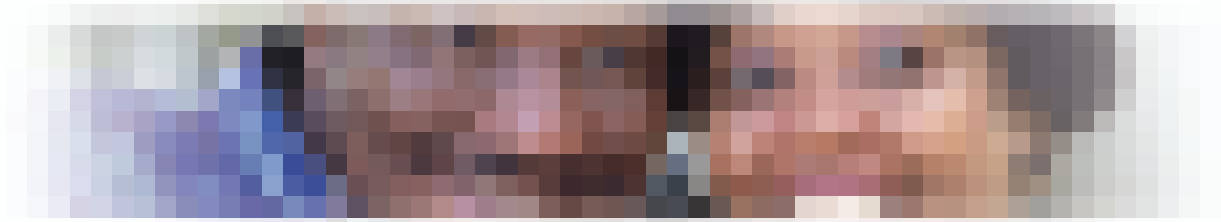
How to request an appeal

This part of Section 6 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request (described in Section 4 of this document), you can appeal. A coverage determination, which includes those described on page 45, may be appealed if you disagree with our decision.

Note: *If we approve your exception request for a non-formulary drug, you cannot request an exception to the copayment we require you to pay for the drug.*



How does the appeals process work?

There are five levels to the appeals process.

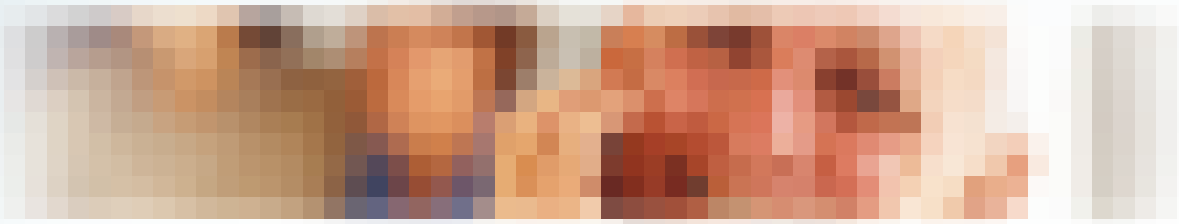
Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

continued

Each appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a coverage determination and an appeal."



Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage determinations—*Our Plan makes a coverage determination about your Part D prescription drug, or about paying for a Part D drug you have already received*

What is a coverage determination?

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact our Plan and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" our decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

– You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service to get help in making this request.

– You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can refer to our Customer Service to ask for this type of decision.

– You ask for an exception to our plan's utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call Customer Service to ask for this type of decision.

– You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can refer to our Customer Service to ask for this type of decision.

– You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the Plan. See Section 1 for a description of these circumstances. You can refer to our Customer Service to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a doctor's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by our Plan).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at BlueRx Member Service Department, P.O. Box 890388, Camp Hill, PA 17089. You can call Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

continued

Asking for a "Standard" or "Fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Customer Service numbers listed on the cover and in the Introduction section for assistance. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, or fax it to 1-412-544-7546. For requests made outside of regular business hours, please mail to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230, telephone 1-800-290-3914 (TTY users, call 1-800-988-0668) and select prompt #3, or fax it to 1-412-544-7546. Be sure to ask for a "fast," "expedited" or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

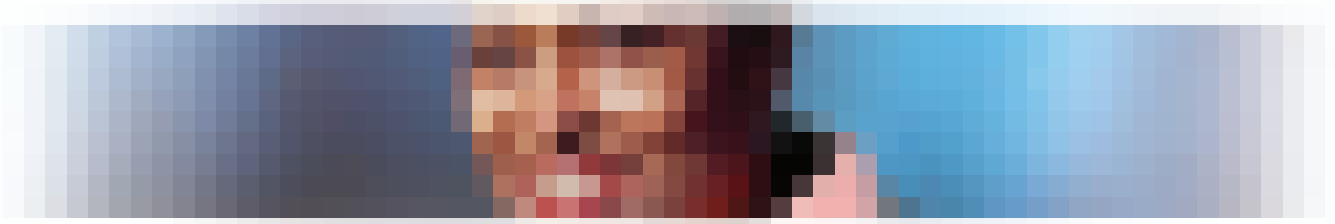
If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules — such as dosage or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**



We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast coverage determination about a Part D drug that you have not received.*

   If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review — sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

continued

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72-hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. *For a fast decision about a Part D drug that you have not received.*

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

Appeal Level 1—*If we deny all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."*

Please call Customer Service if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision." While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different — please refer to "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

In writing: *BlueRx Appeals and Grievance Department*
P.O. Box 535047
Pittsburgh, PA 15253-5047.

By fax, at ***1-412-544-1513***.

By telephone — *if it is a fast appeal — at 1-800-485-9610; TTY users—1-888-422-1226*.

continued

In person, at any of the following walk-in centers:

– Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

– One Pasquerilla Plaza
Johnstown, PA 15901

– 717 State Street
Erie, PA 16501

– Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

– 7248 Tilghman Street
Allentown, PA 18106

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-800-290-3914 (TTY users, call 1-800-988-0668) or write us at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your appeal?

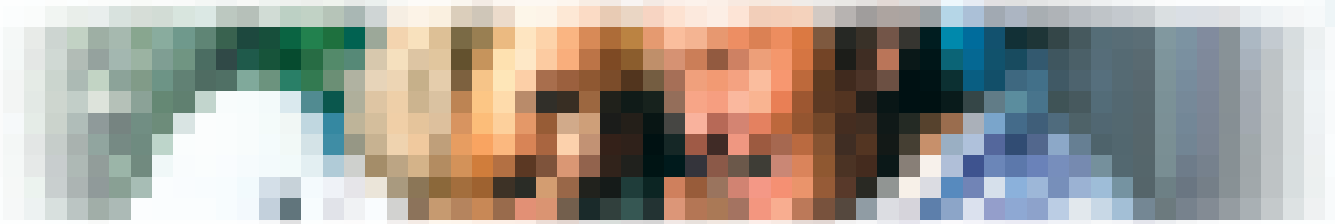
You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Customer Service numbers listed on the cover and in the Introduction section. Or, you can deliver a written request to the address listed in the Introduction or by mail to BlueRx Expedited Review Department,

P.O. Box 535073, Pittsburgh, PA 15253-5073 or fax it to 1-800-894-7947. For requests that are made outside of regular weekday business hours, call BlueRx Expedited Review at 1-800-485-9610 (TTY users, call 1-888-422-1226). Be sure to ask for a "fast," "expedited" or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. *While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Send your standard appeal requests to BlueRx Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047. Send your expedited appeal requests to BlueRx Expedited Review Department, P.O. Box 535073, Pittsburgh, PA 15253-5073.*



How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

   After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

   After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must send payment to you no later than 30 calendar days after we get your request to reconsider our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

continued

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal — or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

Appeal Level 2—*If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization*

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you — only you or your appointed representative may file the request.

If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.*
2. *For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.*

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must pay within 30 calendar days from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

continued

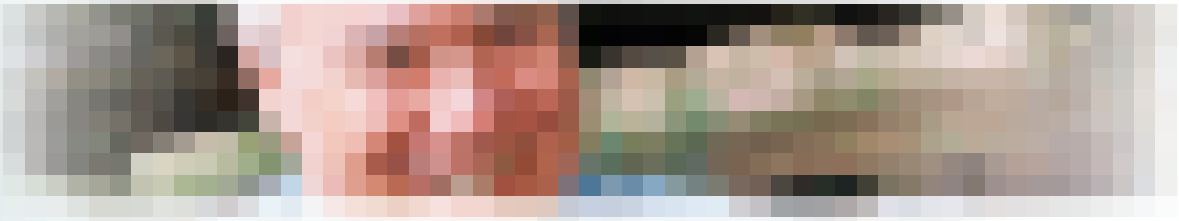
What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110.00 or more.

Appeal Level 3—*If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge*

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to Department of Health and Human Services, Office of Medicare Hearings & Appeals, 200 Public Square, Suite 1300, Cleveland, OH 44114-2316.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110.00. If the dollar value is less than $110.00, you may not appeal any further.



How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.
2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

continued

Appeal Level 4—*Your case may be reviewed by the Medicare Appeals Council*

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. *What happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

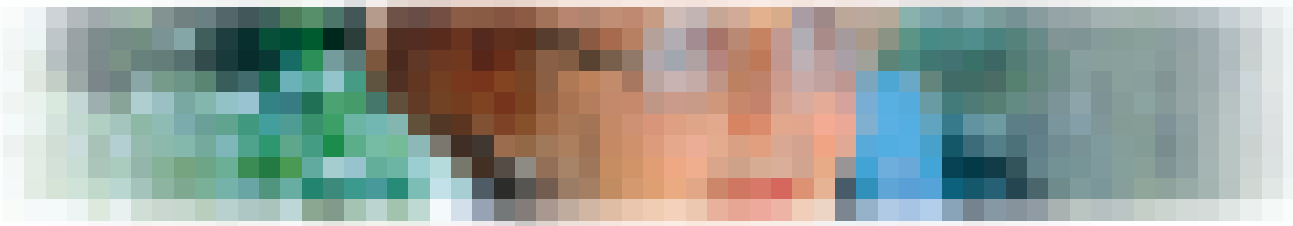
If the Council decides against you

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5— *Your case may go to a Federal Court*

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.



How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once we get notice of a judicial decision in your favor, *what happens next depends on the type of appeal:*

1. *For a decision about payment for a Part D drug you already received.*

   We must send payment to you within 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge decides against you

The Judge's decision is final and you may not take the appeal any further.

What is "disenrollment"?

"Disenrollment" from our Plan means ending your membership with us. **Disenrollment can be** voluntary **(your own choice)** or, in limited circumstances, involuntary **(not your own choice):**

– You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (see "When Can You Disenroll/Switch Prescription Drug Plans?" below).

– There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you move out of our geographic service area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your Rx

If you leave our Plan, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can disenroll from your plan at other times. After you request to disenroll, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy or through our mail order pharmacy service, are listed on our formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Customer Service numbers listed on the cover and in the Introduction section.

continued

What are your options for getting Rx drug coverage if you leave our Plan?

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage *if* this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage. If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must get your Medicare prescription drug coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, "When can you disenroll/switch Medicare Prescription Drug Plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

You may also be able to get back the prescription drug coverage you had before you enrolled in our Plan. Please contact your previous Prescription Drug Plan for more information.

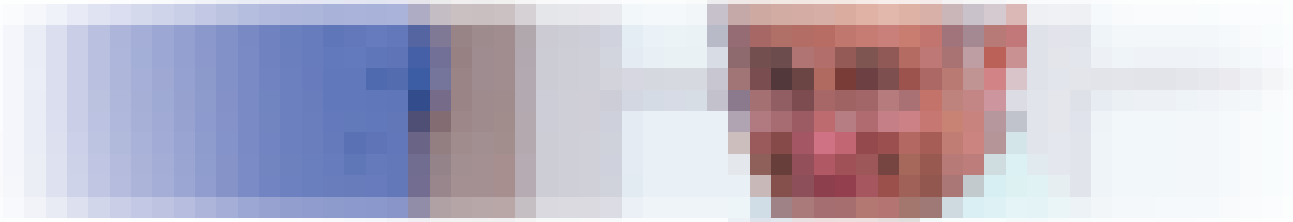
Note: *If you disenroll from our Plan and do not enroll in another Medicare Prescription Drug Plan, or have other prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a penalty if you enroll in a Medicare Prescription Drug Plan at a later date. Refer to Section 3 for more information on the penalty.*

When can you disenroll/switch Medicare Prescription Drug Plans?

In general, you may only disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances.

You can switch your Prescription Drug Plan during the following periods:

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006), you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you did not get this letter, contact the issuer of your Medigap policy.



Annual Coordinated Election Period

During the Annual Coordinated Election Period, anyone with prescription drug coverage may disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare prescription drug coverage.

For coverage beginning in 2006, the annual coordination election period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the annual coordinated election period goes from November 15 through December 31 of each year.

Please remember, if during this election period you disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare prescription drug coverage in the future.

If you join another Prescription Drug Plan during the annual coordinated election period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

Exception for January 1, 2006 through May 15, 2006: If you disenroll from our Plan to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

continued

Special Enrollment Period

Generally, you may not disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year *unless* you qualify for a Special Enrollment Period.

In order to qualify for a Special Enrollment Period, one of the following must apply to you:

– Our Plan no longer offers prescription drug coverage in the area where you live.

– You move outside our Plan's service area.

– You have an involuntary loss of creditable prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.

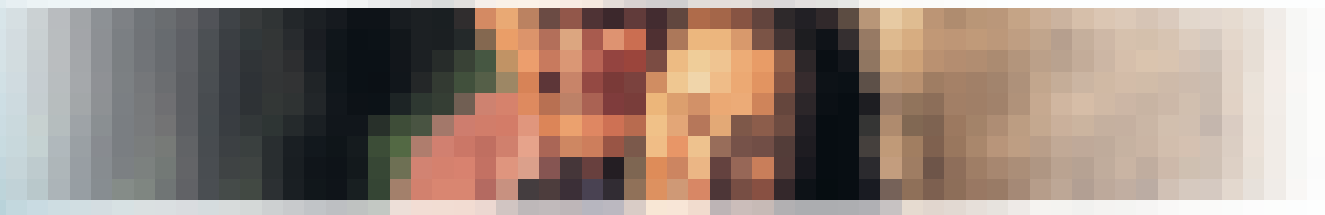
– You were not adequately informed about your loss of creditable prescription drug coverage, or you were not adequately informed that you never had creditable prescription drug coverage.

– Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.

– You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.

– Our Plan's contract with the Centers for Medicare & Medicaid Services is terminated.

– You were a member of a Medicare Advantage Plan with prescription drug coverage and decided to join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.



– You are able to demonstrate that our Plan has substantially violated a material provision in its contract. *This includes, but is not limited to:*

  – If our Plan failed to provide you with prescription drug coverage in a timely manner.

  – If our Plan failed to provide your prescription drug coverage with applicable quality standards.

  – You are able to demonstrate that our Plan misrepresented itself in its marketing.

– You are enrolling in or disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse's current or former employer.

– In certain cases in which the Plan is sanctioned by the Centers for Medicare & Medicaid Services.

– You enroll in or disenroll from your state's Program of All-Inclusive Care for the Elderly.

– You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.

– You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.

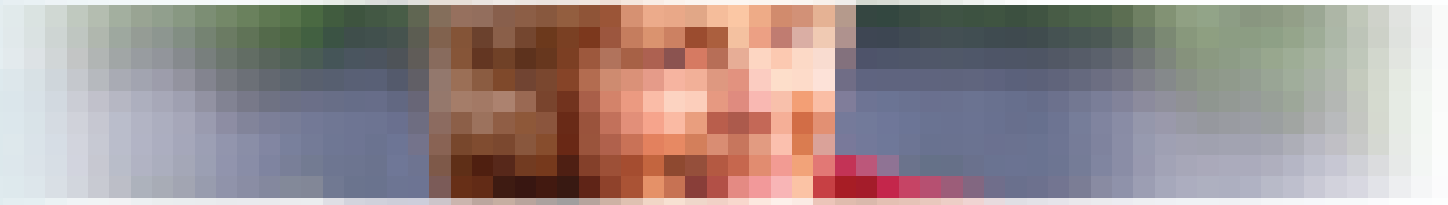
In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Service and we will assist you.

How do you disenroll?

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a disenrollment request. Your request should include your name, Medicare number, Social Security number, date of birth, and requested disenrollment date. (Please note that we may not be able to disenroll you on the date you request.) Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can mail a letter to us at BlueRx Enrollment Department, P.O. Box 535049, Pittsburgh, PA 15253-5049 or fax it to us at 1-412-544-2111. You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

continued

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your "disenrollment date"). Remember, you are still a member of our Plan until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.



When can the Plan disenroll you?

Our Plan can disenroll you for the following reasons:

– You are no longer eligible for Medicare prescription drug coverage.

– If our Plan is no longer contracting with Medicare or leaves your service area.

– When you move out of our Plan's service area.

– You materially misrepresent third-party reimbursement.

– You fail to pay your Plan premium.

– You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.

If you are no longer eligible for Medicare prescription drug coverage

If you lose your eligibility for Medicare prescription drug coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan's service area.

When the Plan is no longer contracting with Medicare or leaves your service area

If we leave the Medicare program or no longer offer prescription drug coverage in the service area where you live, we will notify you in writing. If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's network pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan. (See "When Can You Disenroll/Switch Prescription Drug Plans?" on page 64 for specific information on special enrollment periods.)

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When you move out of our Plan's service area

If you plan to move, please call our Customer Service numbers listed on the cover and in the Introduction section to find out if the place you are moving to is in our Plan's service area. If you move permanently out of our service area, you will need to leave ("disenroll" from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

You materially misrepresent third-party reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third-party reimbursement, our Plan has the right to decline you future enrollment in our Prescription Drug Plan.

continued

You fail to pay the Plan premium

If you fail to pay your Plan premium, our Plan has the right to disenroll you. Our Plan will send you a written notice in an effort to collect the unpaid premiums. Failure to comply with payment will result in disenrollment from the Plan.

In addition, if you are disenrolled from Plan for failure to pay your premium, Plan has the right to decline your future enrollment in our Prescription Drug Plan until your debt has been paid.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as standard Medicare prescription drug coverage for 63 days or longer, then you will pay a penalty the next time you enroll in a Medicare Prescription Drug Plan.

You engage in disruptive behavior, provide fraudulent information when you enroll or abuse your enrollment card

You may be asked to leave our Plan in the following circumstances:

– If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are members of our Plan. We cannot make you leave (i.e., disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.

– If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.

– If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We cannot ask you to leave our Plan because of your health

No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our Plan

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area:

Office for Civil Rights, Philadelphia Office
U.S. Dept. of Education
Wanamaker Building
100 Penn Square East, Suite 515
Philadelphia, PA 19107-3323
Telephone: 1-215-656-8541
Fax: 1-215-656-8605

If you need help with communication, such as help from a language interpreter, please call our Customer Service numbers listed on the cover.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

continued

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Customer Service numbers listed on the cover.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any network pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a network pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 6.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 6.

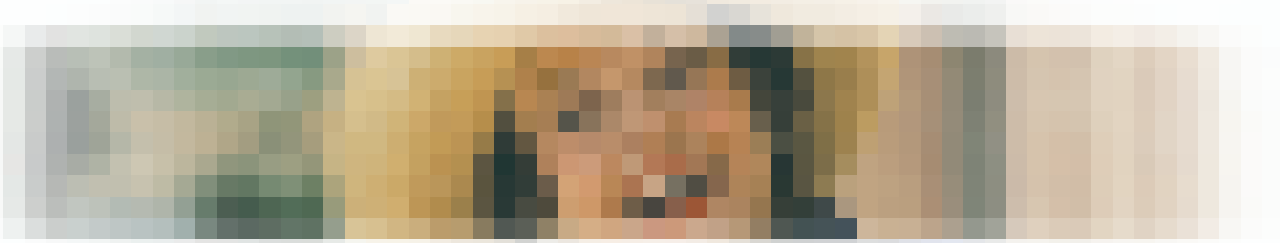
If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed *against* us in the past. To get this information, call our Customer Service numbers listed on the cover.

Your right to get information about your drug coverage and costs

This Evidence of Coverage tells you what you have to pay for prescription drugs as a member of the Plan. If you need more information, please call our Customer Service numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 6 for more information about filing an appeal.

Your right to get information about our Plan and our network pharmacies

You have the right to get information from us about Highmark Senior Resources Inc. and BlueRx Plans. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Customer Service at the phone number listed on the cover.



How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Service numbers listed on the cover and in the Introduction section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction, page 10, tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

continued

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Service numbers listed on the cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

What are your responsibilities as a member of our Plan?

Along with the rights you have as a member of our Plan, you also have some responsibilities.

Your responsibilities include the following:

– Become familiar with your coverage and the rules you must follow to get care as a member. You can use this Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone numbers listed on the cover if you have any questions.

– Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.

– Pay your plan premiums and any copayments you may owe for the covered drugs you get. You must also meet your other financial responsibilities that are described in Section 3.

– Let us know if you have any questions, concerns, problems or suggestions. If you do, please call our Customer Service numbers listed on the cover.

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of your state may also apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like us, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

For the terms listed below, this section either gives a definition or directs you to a place in this Evidence of Coverage that explains the term

Appeal – A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug. Section 6 explains what appeals are, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are sometimes not available until after the patent on the brand-name drug has expired. Section 4 explains Plan coverage for brand name drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination – The decision the Plan makes about the prescription drug benefits you are entitled to get under the plan, and the amount that you are required to pay for a drug. Section 6 discusses these decisions.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan. Section 4 tells you what drugs are covered by BlueRx.

Creditable Coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage. Section 5, "If you are a member of an employer or retiree group" mentions creditable coverage.

Customer Service – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Introduction for information about how to contact Customer Service.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses disenrollment.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception). See Section 6.

Formulary – A list of covered drugs provided by the plan. Section 4 talks about our formulary.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Section 4 explains Plan coverage for generic drugs.

Grievance - A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about grievances.

Late Enrollment Penalty – If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium. See Section 3.

Medically Necessary – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor. See Section 4.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). See Introduction.

continued

Medicare Advantage Plan with Prescription Drug Coverage – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. See Section 7.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. See Section 1.

"Medigap" (Medicare supplement insurance) Policy – Many people who have Original Medicare also buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage. See Section 5.

Member (member of our Plan) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS). See Section 5.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. See Section 1.

Non-preferred Brand Name Drug – A brand name drug that is not included on the preferred drug listing. BlueRx Complete provides coverage for these drugs, but at a lower benefit level (you pay higher cost-sharing). See Section 4.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

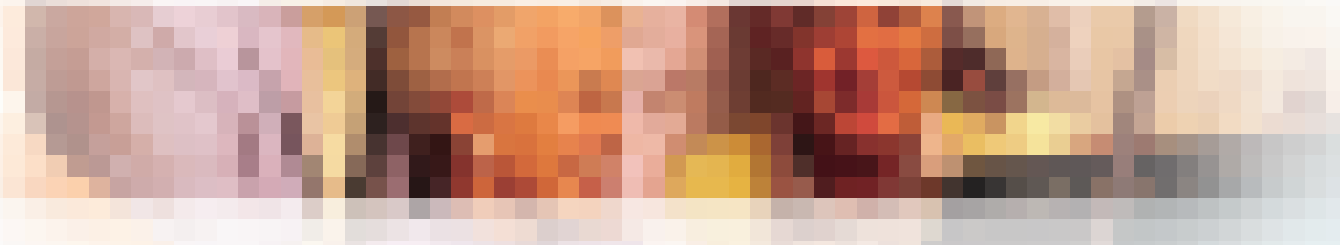
Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug unless it is covered under Part A or Part B. See Section 4.

Preferred Brand Name Drug – A brand name drug that is included on the preferred drug listing. BlueRx Complete provides coverage for these drugs at the higher benefit level (you pay lower cost-sharing). See Section 4.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some services are covered only if your doctor or other plan provider gets "prior authorization" from us. Covered services that need prior authorization are marked in the formulary. See Section 4.

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan. See Section 1.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. See Section 2.



A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.

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